Premier Plastic Surgery Center of New Jersey

310 Madison Avenue, Suite 100, Morristown, NJ 07960
Phone: 973.889.9300 Fax: 973.889.9400 Web: www.drbrianglatt.com

Patient's Name.....Date of Birth.....

Address.....City.....State.....Zip.....

Home #.....Cell #.....Email.....

SS #.....Gender: Female___ Male___ **Marital Status** Single___ Married___ Other___

Employer.....Occupation.....

Work #.....Ext #.....Is it ok to call you at work? : Yes___ No___

Address.....City.....State.....Zip.....

Release of Protected Health Information (PHI)

Due to HIPAA constraints, we are unable to speak to anyone regarding any aspect of your care, billing or appointments without your expressed written consent. If you wish to allow us to speak to anyone other than you, please include their name below and sign.

.....

Name of person you authorize Your Signature

Office Policies

❖ Privacy Policy

The privacy of your medical information is of the utmost importance to our practice. We adhere to all laws governing protection of your medical information as outlined in the Health Insurance Portability and Accountability Act of 1996. You may obtain a copy of our Privacy Policy at the time of your visit to our office. It may be necessary to release your protected health information to banks, insurance companies, financing companies and/or credit card entities to facilitate your payment. By initialing below I consent to allow Premier Plastic Surgery Center of New Jersey to use and disclose this information to the above named entities when such information is requested to process a payment. **Initial**:_____

❖ Financial Policy Summary

Office visits are payable on the day of service. For your convenience, we accept American Express, Discover, MasterCard, Visa, checks and cash. Any returned check will incur a bank fee charge. Unpaid accounts are subject to collection fees up to 50% of the outstanding balance. Credit Card refunds incur a 3% service charge.

Dr. Glatt participates in Atlantic Health System PPO. If you have insurance other than the above you will be utilizing your out of network benefits. As a courtesy we will submit insurance claims on your behalf; however any balance remains your responsibility. A copy of our complete Financial Policy is available at our office and will be provided to you upon request. **Initial**:_____

❖ Communication

May we send mail to your home address? Yes___ No___
May we contact you via email? Yes___ No___
May we contact you via text message? Yes___ No___

My signature certifies that I have read, understand and agree to the above policies. .....

Signature Date

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Medications and Allergies

Pharmacy:.....Phone:.....

Are you taking aspirin? No___ Yes___ If yes: 81mg (baby)___ 325mg___

Are you taking Coumadin? No___ Yes___

Usage of non-steroidal anti-inflammatory drugs (ex. Motrin, Aleve etc.)

Daily___ Occasionally___ Weekly___ Rarely___ Never

Are you currently taking medications, vitamins or supplements? No___ Yes___ If "Yes", list below:

Medication / Supplements Dosage

.....

.....

.....

Are you allergic to latex? No___ Yes___ Not Sure___

Are you allergic to nickel? No___ Yes___ Not Sure___

Do you have any allergies? No___ Yes___ Not Sure___

If you answered "Yes", please list your allergies:.....

.....

.....

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Medical History

This Medical History Form is part of a Confidential Medical Record and will not be released unless you have authorized us to do so. The information contained in this form will be used by Dr. Glatt in decisions regarding your medical care and treatment. Please answer all questions to the best of your knowledge.

Name.....Date of Birth.....Today's Date.....

Address.....City.....State.....Zip.....

Height.....Weight.....Date of last physical exam.....

Primary Physician.....Phone.....

Address.....City.....State.....Zip.....

Emergency Contact.....Phone.....

Please check any conditions below that you have or had in the past (indicate date(s) of occurrence).

- ☐ Blood Clots in your legs
- ☐ Blood Clots in your lungs
- ☐ Diabetes
- ☐ Tuberculosis
- ☐ Arthritis
- ☐ Hypertension
- ☐ CAD (Coronary Artery Disease)
- ☐ Hypercholesterol
- ☐ Heart Attack
- ☐ Congenital Heart Disease
- ☐ Rheumatic Heart Disease
- ☐ Hepatitis
- ☐ Stomach Ulcers
- ☐ Colitis
- ☐ Goiter/Thyroid Disease
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Pneumonia
- ☐ Bronchitis
- ☐ Bleeding Tendency
- ☐ Migraine Headaches
- ☐ Epilepsy
- ☐ Stroke
- ☐ HIV+
- ☐ Cold Sores/Fever Blisters
- ☐ Herpes Genital
- ☐ Cancer
- ☐ Kidney Disease
- ☐ Please list other not on list:
- ☐ No medical issues.

Do you have any children? No___ Yes___
If Yes, what are their ages?.....

Have you ever smoked cigarettes? No___ Never___ Yes___
If Yes, currently, how many per day? .....For how long?.....
If you previously smoked and have quit, when did you quit?.....

Medical History (continued)

Alcohol Usage No___ Yes___
If Yes, what type and how much?.....

Do you use or have you used recreational drugs? No___ Yes___
If Yes, what and how often?.....

Have you ever had treatment by a counselor, psychiatrist or psychologist? No___ Yes___
If Yes, when and for what?.....

If so, were you prescribed any medication as part of this treatment? No___ Yes___
If Yes, list medication (s) prescribed:.....

Do you have any implants / artificial limbs / prostheses? No___ Yes___
If Yes, where?.....

Do you have a pacemaker or Automatic Implantable Cardioverter Defibrillator (AICD)? No___ Yes___

List name and date of ANY surgery you have had:.....

.....

Have you ever had an adverse reaction to anesthesia / surgery? No___ Yes___
If Yes, explain:.....

Women Only

Hormone Replacement Therapy? Never___ Current Usage___ Past___

Oral Contraceptives? Never___ Current Usage___ Past___

Date of most recent mammogram:.....

Are you still having regular monthly menstrual periods?.....

Have you ever had a discharge from the nipple of your breast? No___ Yes___ When?.....

Do you regularly have PAP smears? No___ Yes___ If yes, date of last?.....

How many pregnancies?.....Cesarean deliveries?.....

What are the ages of your children?.....

Are you planning on having more children? No___ Yes___

Sign Below

I certify that the medical information I have provided is accurate and complete to the best of my knowledge.

.....

Signature Date