UMANSKY MEDICAL CENTER FOR PLASTIC SURGERY

William Umansky, M.D., F.A.C.S
A Medical Corporation

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PATIENT NAME (LAST, FIRST, MI, MAIDEN):______________________________

HOME ADDRESS:______________________________
(STREET) (CITY) (ZIP)

HOME PHONE: ______________ (CELL) ______________ (WORK) ______________

SEX: (M / F) DATE OF BIRTH:______________ AGE:__________ MARITAL STATUS: M S W D SEP
\# OF CHILDREN __________

PATIENT EMAIL ADDRESS:______________________ MAY WE CONTACT YOU VIA EMAIL: YES / NO

PATIENT'S EMPLOYER: ______________________ SSN:______________
EMPLOYER'S ADDRESS: ______________________ DRIVER'S LIC #______________

SPOUSE/PARENT NAME:______________________________
SPOUSE/PARENT ADDRESS:______________________________
(STREET) (CITY) (ZIP)

HOME PHONE:______________________ SSN:______________________
WORK PHONE:______________________ CELL:______________________
EMPLOYER: ______________________ ADDRESS:______________________

EMERGENCY CONTACT:______________________ PHONE:______________________
RELATIONSHIP TO PATIENT______________________

PRIMARY INSURANCE:______________________ POLICY #:______________________
NAME OF INSURED:______________________ GROUP #:______________________

SECONDARY INSURANCE:______________________ POLICY #:______________________
NAME OF INSURED:______________________ GROUP #:______________________

REFERRED BY:______________________

MEDICAL HISTORY (WITHIN THE LAST 5 YEARS)

PRIMARY CARE PHYSICIAN:______________________________
MEDICATIONS/DRUGS/VITAMINS CURRENTLY TAKING:______________________________
ALLERGIES TO ANY MEDICATIONS:______________________________
LATEX ALLERGY OR LATEX SENSITIVITY: YES______________ NO______________
PREVIOUS SURGERIES/HOSPITALIZATIONS:______________________________
DO YOU SUFFER FROM: HIGH BLOOD PRESSURE__________ HEART DISEASE__________
DIABETES__________ ANY CHRONIC ILLNESS__________ OTHER CONDITION__________
GENERAL HEALTH: GOOD__________ FAIR__________ POOR__________
DO YOU SMOKE?__________ HOW MUCH?__________

Each patient (or responsible party) is financially responsible for services rendered. While we are pleased to assist in the preparation of submission of insurance forms, the obligation of payment remains that of the patient (responsible party). I authorize the release of any medical information necessary to process this claim. I understand I am financially responsible for the unpaid balance of all accounts in the event this authorization is insufficient to liquidate this account. I hereby assign and transfer any insurance benefits paid to me for professional services to be paid directly to the physicians. ALL COSMETIC SURGERIES ARE TO BE PAID 21 DAYS IN ADVANCE OF THE SURGICAL DATE. We have a no show & 48 hour late cancellation policy. In the event of a late cancellation or no show, your credit card on file will be charged a $50 fee. This fee cannot be applied toward any services. Should you have any questions regarding fees or terms, please do not hesitate to ask.

X______________________________ ______________________
Signature of patient, responsible party or legal guardian DATE