

Date _____

Patient's Name _____

Last

First

Middle

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Other Phone _____

O.K. to Leave Messages? _____ E-mail _____

Drivers License # (include State) _____ O.K. to Contact for Events/Promotions

Age _____ Birthdate ____/____/____ SS# ____-____-____ Sex Female Male

Marital Status Single Married Divorced Other: _____

Patient's Employer _____ Occupation _____

Work Phone _____ Ext: _____ Is it okay to call you at work? Yes No

Address _____
Street & Suite # City State Zip

Primary Health Insurance Company _____

Policy # _____ Group # _____ Ins. Phone _____

Insured: Name _____ DOB _____ SSN# _____

Referred By Friend _____
 Relative _____
 Doctor _____
 Patient _____

Website DrGlicksman.com
 LookingYourBest.com
 BreastAugmentation.com
Publications NJ Monthly Yellowpages Savvy Magazine
 Coast Star Living In Magazine

Describe What Brings You Here: _____

If Injury, Date _____ Motor Vehicle Animal Bite At Work Other _____

Most recent Mammogram Date:

RESULT:

Medical History

Height _____ Weight _____ Present Bra Size _____ Bra Manufacturer _____

Previous Surgery (Please List)

Operation

Year

Complications, if any

Serious Injuries (Please List)

Operation

Year

Complications, if any

Medications (Please List)

Maternal History

Have you ever been pregnant? Yes No If Yes, how many times? _____ How many children do you have? _____

Are you now pregnant? _____ Are you planning more children? Yes No Don't Know

General

Are you allergic to any pills, drugs, or medicines? Yes No If yes, name _____

Have you ever had a reaction to any anesthetic? Yes No _____

Do you smoke? Yes No _____

Do you form bad scars or keloids? Yes No _____

Have you ever had psychiatric care? Yes No _____

Have you seen other plastic surgeons about the SAME problem that brings you here? Yes No _____

I understand that office visit charges are payable on the day service is rendered. I authorize Dr. Glicksman to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Dr. Glicksman and myself.

Signature _____ **Date** _____