

STANLEY P. GULIN, M.D., F.A.C.S.

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AESTHETIC AND RECONSTRUCTIVE PLASTIC SURGERY

DIPLOMATE, AMERICAN BOARD OF PLASTIC SURGERY

PATIENT INFORMATION

Date: _____

Name of Patient: _____
Last First Middle

Address: _____ City: _____ State: _____ Zip: _____

Home Telephone: _____ Work Phone: _____ Cell: _____

Email Address: _____ @ _____ May we e-mail you Yes _____ No _____

Other Address: _____ Telephone: _____

Birth Date: _____ Age: _____ Sex: _____ SSN: _____ Marital Status: _____

Spouse or Parent/Guardian Name: _____ Phone: _____

Emergency Contact Name: _____ Phone: _____

Referred by Dr. _____ Friend: _____ Other: _____

Reason for visit: _____

Primary Physician: _____ Telephone: _____

Employer Info: _____ Telephone: _____

MEDICAL HISTORY

Do you have any medical problems: _____

Prior Surgeries: _____

Height: _____ Weight: _____ Do you have high blood pressure? _____

Do you have any Bleeding Problems: _____ Do you have any Easy Bruising Problems: _____

If yes explain: _____

Are you allergic or sensitive to any drugs or medications? _____

What medications are you presently taking, including over the counter medicines? _____

Have you ever had difficulty with Local Anesthesia? _____ General Anesthesia? _____

If yes explain: _____

Do you have: Heart valve murmur or any other cardiac problems? _____

If yes explain: _____

Approximate daily consumption of Tobacco: _____ Aspirin, Motrin, Advil _____

INSURANCE INFORMATION

Primary Insurance: _____ Address: _____

Group# _____ ID# _____

Policy Holder Name: _____ Relationship: _____

Medicare # _____ Secondary: _____

PLEASE NOTE: WE ARE NOT PARTICIPATING WITH MEDICARE, HOWEVER WE WILL FILE A CLAIM FOR YOU

The undersigned hereby acknowledges that I have been informed of my rights under the HIPAA Privacy Notice. I was given ample opportunity to ask questions of the staff regarding my HIPAA rights. I further understand that a copy of my rights under HIPAA will be furnished to me upon my request.

I hereby authorize my doctor, Stanley P. Gulin, M.D., to finish any designated insurance company all information necessary to file any health insurance claims. I hereby assign all medical and/or surgical benefits, to include major benefits to which I am entitled, including Medicare, private insurance, and any other health plans to Stanley P. Gulin, M.D. I understand that I am financially responsible for all charges whether or not paid by my insurance carrier.

Patient Signature

Date

DR GULIN