ADVANCED PLASTIC SURGERY OF LONG ISLAND, PLLC

1800 Merrick Road
Merrick, New York 11566
Tel 516-377-2738 Fax 516-377-7705

PATIENT INFORMATION

***** Provide Your Driver's License to Receptionist*****

Patient Name: ____
Last First Middle

Age: __________ **Date of Birth:** _____/_____/_____ **Sex:** M / F **Marital Status:** S / M / W / D

Home Address: ____ **Apt #:** _________

____
City State Zip Code

Home Telephone: ________________________ **Work Telephone:** ________________________

Cell Number: ____________________________ **Email Address:** __________________________

Do we have permission to leave a message on all contacts numbers listed above? Yes // No
Do we have permission to email you at the email address provided above? Yes // No

Patient's Social Security #: _______ - _______ - _______ **Occupation:** ____________________

Spouse's Name: ___________________________________ **Date of Birth:** _____/_____/_____
Last First M.I.

Social Security #: ______ - ______ - ______ **Occupation:** _________________

Person to contact in case of an emergency:

Name: _____________________ Telephone No.: _________________ Relationship: __________

<u>If Patient is a MINOR, please complete:</u>

Father's Name: ___________________________________ **Date of Birth:** _____/_____/_____
Last First M.I.

Social Security #: ______ - ______ - ______ **Occupation:** _________________

Mother's Name: ___________________________________ **Date of Birth:** _____/_____/_____
Last First M.I.

Social Security #: ______ - ______ - ______ **Occupation:** _________________

Name of Employer*:____

Work Address: ____ **Ste #:** _________

____
City State Zip Code

** If patient is a MINOR, provide employment information for the **insured individual** (i.e., the policyholder).*

Name of Spouse's Employer:____

Work Address: ____ **Ste #:** _________

____
City State Zip Code

Primary Insurance: ________________________ **Policy/ID No.:** ________________________

Relationship to Subscriber: ____

If subscriber other than patient:

Subscriber Name: _________________________________ **Date of Birth:** _____/_____/_____

Last First M.I.

Social Security #: ______ - ______ - ______ **Employer:** ________________

APSLI, PLLC accepts assignment on all Medicare claims. The fees are set by the federal government. You will be billed for 20% of the fee that is not paid by Medicare (or more if your deductible has not been met).

Primary Physician/Pediatrician

Name: ____

Address: ____ **Ste. #:** _________

____

City State Zip Code

Telephone Number: ____

Reason for today's visit: ____

Allergies to any foods or medications: Yes / No **If yes, list:** ____________________________

Do you have or have you had any of the following (if yes, specify date of occurrence):

Bleeding Tendency	No / Yes__________	Urinary Problems	No / Yes__________
Digestive Problems	No / Yes__________	Visual Problems	No / Yes__________
Dermatologic Problems	No / Yes__________	Arthritis	No / Yes__________
Ear, Nose, Throat Problems	No / Yes__________	Cancer	No / Yes__________
Genital (gyn, prostrate, etc.)	No / Yes__________	Diabetes	No / Yes__________
Musculo-skeletal Disorders	No / Yes__________	Heart Disease	No / Yes__________
Neurologic Disorders	No / Yes__________	Hepatitis	No / Yes__________
Psychiatric Disorders (depression, anxiety, eating disorder, etc.)	No / Yes__________	High Blood Pressure	No / Yes__________
Respiratory Problems	No / Yes__________		

Other: ____

Are you currently taking any medication: Yes / No **If yes, list:**__________________________

Any prior surgeries: Yes / No **If yes, list type and year:** ________________________________

Do you smoke? Yes / No **If yes, how much per day?** ___________________________________

Have you smoked in the past? Yes / No **If yes, how long/amt per day?**___________________

Do you consume alcohol? Yes / No **If yes, frequency and amt?** ________________________

I, the undersigned, hereby consent to care and treatment now and in the future. In the event that my insurance company is billed, I authorize payment of medical benefits to the physician. If my insurance company is not billed or if my insurance company fails to pay for services or does not pay a claim in full, I understand that I am responsible for payment of charges for services rendered. I authorize the release of any medical information necessary to process and collect on my claim.

____ ____________________________

Signature Date

____ ____

Print Name If not self, relationship to patient