PATIENT INFORMATION SHEET
5 EAST 82ND STREET

Name: _____ Date: _____
Address: _____ SSN #: _____ / _____ / _____
City: _____ State: _____ Zip: _____ DOB: _____ / _____ / _____
Home #: ( ) _____ Work #: ( ) _____
Mobile #: ( ) _____ E-mail: _____

Employer: _____ Occupation: _____
Address: _____
City: _____ State: _____ Zip: _____

Marital Status (circle): Single / Married / Divorced / Widowed
If Married, Spouse's Name: _____ Home #: ( ) _____
Emergency Contact: _____ Work #: ( ) _____
Relationship: _____ Mobile #: ( ) _____

Referred by: _____
Purpose of Consult: _____

Primary Insurance: _____
Policy #: _____ Group #: _____
Policy Holder Information (if different from yourself):
Name: _____ SSN #: _____ / ____ / _____ DOB: ___ / ___ / ___
Employer: _____
Address: _____ Phone #: ( ) _____
Secondary Insurance: _____
Policy Holder: _____
Policy #: _____ Group #: _____

Physician: _____ Phone #: ( ) _____
Height: _____ Weight: _____ Allergies: _____
Circle YES or NO to the following:

High Blood Pressure:	YES / NO	Asthma:	YES / NO
Alcohol Use:	YES / NO	Diabetes:	YES / NO
Smoking History:	YES / NO	Hepatitis:	YES / NO
If yes, how long?: _____		Heart Disease:	YES / NO

Current Medications (please include dosage): _____
_____
Previous Surgeries (including cosmetic): _____
_____

I understand the fee for a cosmetic consultation visit is $100, payable at the time of the visit, and that functional & reconstructive problems may be billed additionally to my insurance carrier. I also agree to be responsible for any deductible and/ or co-payments required by my plan.

Signature: _____ ( ) Copy of Photo ID