Glicksman Plastic Surgery

Date ______________

Patient's Name ____
Last First Middle

Address ____
Street & Apt # City State Zip

Home Phone ______________ Cell Phone ______________ Home Phone ______________

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

❒ O.K. to Contact for Events/Promotions

Drivers License
(include State) ______________

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 ______________

Websites
❒ www.drglicksman.com ❒Facebook
❒ www.theplasticsurgerychannel.com
❒ www.cohesiveimplants.com

Publications
❒ NJ Monthly

Describe What Brings You Here: ____

____

____

____

If Injury, Date ______________ ❒ Motor Vehicle ❒ Animal Bite ❒ At Work ❒ Other ______________

Medical History

Height _________ Weight ___________ Present Bra Size __________ Bra Manufacturer __________________________

Most recent mammogram ___________________

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** ______________________