# UMANSKY PLASTIC SURGERY

**William Umansky, M.D., F.A.C.S**
A Medical Corporation

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A Medical Corporation

PATIENT NAME (LAST, FIRST, MI, MAIDEN):_____
HOME ADDRESS:_____
(STREET) (CITY) (ZIP)

HOME PHONE: _____ (CELL) _____ (WORK) _____

SEX: ( M / F ) DATE OF BIRTH:_____ AGE:_____ MARITAL STATUS: M S W D SEP
# OF CHILDREN _____

**PATIENT EMAIL ADDRESS**:_____ MAY WE CONTACT YOU VIA EMAIL: YES / NO

PATIENT'S EMPLOYER: _____ SSN:_____
EMPLOYER'S ADDRESS: _____ DRIVER'S LIC #_____

SPOUSE/PARENT NAME:_____
SPOUSE/PARENT ADDRESS:_____
(STREET) (CITY) (ZIP)
HOME PHONE:_____ SSN:_____
WORK PHONE:_____ CELL:_____
EMPLOYER: _____ ADDRESS:_____

EMERGENCY CONTACT:_____ PHONE:_____
RELATIONSHIP TO PATIENT_____ EMAIL:_____

PRIMARY INSURANCE:_____ POLICY #:_____
NAME OF INSURED:_____ GROUP #:_____

SECONDARY INSURANCE:_____ POLICY #:_____
NAME OF INSURED:_____ GROUP #:_____

**REFERRED BY**:_____

## MEDICAL HISTORY (WITHIN THE LAST 5 YEARS)

**PRIMARY CARE PHYSICIAN**:_____
MEDICATIONS/DRUGS/VITAMINS CURRENTLY TAKING:_____
ALLERGIES TO ANY MEDICATIONS:_____
**LATEX ALLERGY OR LATEX SENSITIVITY**: YES_____ NO_____
PREVIOUS SURGERIES/HOSPITALIZATIONS:_____
DO YOU SUFFER FROM: HIGH BLOOD PRESSURE_____ HEART DISEASE_____
DIABETES_____ ANY CHRONIC ILLNESS_____ OTHER CONDITION_____
GENERAL HEALTH: GOOD_____ FAIR_____ POOR_____
DO YOU SMOKE?_____ HOW MUCH?_____

Each patient (or responsible party) is financially responsible for services rendered. While we are pleased to assist in the preparation of submission of insurance forms, the obligation of payment remains that of the patient (responsible party). I authorize the release of any medical information necessary to process this claim. I understand I am financially responsible for the unpaid balance of all accounts in the event this authorization is insufficient to liquidate this account. I hereby assign and transfer any insurance benefits paid to me for professional services to be paid directly to the physicians. ALL COSMETIC SURGERIES ARE TO BE PAID 28 DAYS IN ADVANCE OF THE SURGICAL DATE. We have a no show & 48 hour late cancellation policy. In the event of a late cancellation or no show, your credit card on file will be charged a $50 fee. This fee cannot be applied toward any services. Should you have any questions regarding fees or terms, please do not hesitate to ask.

X_____ _____
Signature of patient, responsible party or legal guardian DATE