Paul J. LoVerme, M.D., FACS

AESTHETIC AND RECONSTRUCTIVE PLASTIC SURGERY

(PLEASE COMPLETE ALL ITEMS AND PRINT)

PATIENT INFORMATION APPOINTMENT DATE_____

Patient's Name_____Age_____ Date of Birth_____

Home Address_____City_____State_____Zip_____

Home Phone Number_____ Cell Phone Number_____ SS#_____

Drivers License No._____E-Mail_____

Married_____ Single_____ Widow(er)_____ Divorced_____ Separated_____

Patient's Occupation_____Employer_____

Business Address_____

Business Phone_____

Name of Spouse/Parent_____

Spouse/Parent's Occupation_____

Spouse/Parent's Employer_____

Employer's Address_____

Business Phone_____Ext_____Social Security No._____

Nearest Relative Not Living With You_____

Relationship_____Phone_____

Address_____

Family Physician/Pediatrician_____

Address_____

Opthalmologist_____

Address_____

Whom may we thank for referring you?_____

Has the office previously treated any member of your family? Yes__No__If so, When_____

AUTHORIZATION FOR USE OF PHOTOGRAPHS

I authorize Dr. LoVerme to use any photographs that he may take of me for teaching, lectures, or illustration in medical publications, for insurance purposes, or to be shown to prospective patients.

Signed_____Date_____

PATIENT NAME_____DATE_____AGE_____

WHAT PROBLEM DO YOU WANT TO
DISCUSS WITH THE DOCTOR?

DO NOT WRITE BELOW

BP_____ P_____

BESIDES THE REASON FOR THIS CONSULTATION, WOULD YOU LIKE THE DR. TO DISCUSS OTHER PROCEDURES THAT WOULD ENHANCE YOUR APPERANCE?_____

IF INJURY, Date_____
Motor Vehicle_____ Pedestrian_____
Animal Bite_____At Work_____
Other_____Specify_____

MEDICAL HISTORY

Height_____Weight_____

Any Weight □ Loss or □ Gain? Yes_____ No_____

If yes, how much_____

PREVIOUS SURGERY OR SERIOUS INJURY (please list)
Operation Year Complications, if any

MEDICATIONS , DRUGS
Are you presently taking any medication □ Yes □ No
Please list all medications you are now taking

List All Medications and Dosages

____Birth control pills
____Hormones
____Diuretics (water pills)
____Steroid Medications
____Blood Pressure Pills
____ Blood Thinners
____Heart Medications
____Aspirin, bufferin,etc
____Tranquilizers
____Thyroid
____Sleeping Pills
_____Others_____
___Appetite Suppressants
___Vitamins, Herbs_____

Have you ever had a drug or alcohol problem?

_____Yes _____No

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☐

Date of last menstrual period_____

GENERAL — If yes, comment

Are you allergic to any pills, drugs, or medicines or tape? Yes☐ No☐_____

Have you ever had a bad reaction to a GENERAL anesthetic? Yes☐ No☐_____

Have you ever had a bad reaction to a LOCAL anesthetic? Yes☐ No☐_____

Do you have high blood pressure? Yes☐ No☐_____

Do you bleed unusually easily (from cuts or surgery)? Yes☐ No☐_____

Do you have large scars or keloids? Yes☐ No☐_____

Do you have frequent infections or boils? Yes☐ No☐_____

Have you ever had any significant emotional problems? Yes☐ No☐_____

Have you ever had psychiatric care? Yes☐ No☐_____

Have you ever been advised to see a psychiatrist? Yes☐ No☐_____

Have you seen other plastic surgeons about the SAME problem which brings you here? Yes☐ No☐_____

Have you ever been tested for HIV? Yes☐ No☐_____
Results_____Date_____

Have you ever had a blood transfusion? Yes☐ No☐_____

HABITS

Alcohol (beer, wine, whiskey) ☐Daily ☐Moderate ☐Rarely ☐Never

Tobacco

☐No If yes: ☐Cigarettes_____packs per day ☐ Cigars_____per day

Have you ever smoked? ☐ Yes ☐ No When did you quit?_____

FAMILY HISTORY

	If Living		If Deceased		Has any Relative had	
	Age	Health	Age at Death	Cause		Who
Father					Cancer	
Mother					Diabetes	
Brother/Sister					Heart Trouble	
					High Blood Pressure	
					Epilepsy	
					Tuberculosis	
Son/Daughter					HIV/AIDS	

LOCAL PROBLEMS Have you had any serious illness of the following? (Circle if YES)

Brain Nose Heart Blood Extremities

Eyes Breasts Abdomen Reproduction Endocrine (Diabetes)

Ears Lungs Urinary Nervous Other

If circled, please explain_____

_____

PLEASE CHECK ONE

Medicare_____ BC/BS of NJ_____Priv. line_____ Workman's Comp._____

MVA_____ HMO_____ Self_____

PRIMARY HEALTH INSURANCE COMPANY

_____SUBSCRIBER
RELATION TO PATIENT

_____
TELEPHONE ID# EFFECTIVE DATE

_____
SOCIAL SECURITY # SUBSCRIBER'S DATE OF BIRTH

SECONDARY HEALTH INSURANCE COMPANY

_____SUBSCRIBER
RELATION TO PATIENT

_____
TELEPHONE ID# EFFECTIVE DATE

_____
SOCIAL SECURITY # SUBSCRIBER'S DATE OF BIRTH

WORKMAN'S COMPENSATION

_____INSURANCE
CARRIER'S NAME AND ADDRESS

_____
CLAIM NUMBER TELEPHONE

_____
DATE OF ACCIDENT CONTACT PERSON

MOTOR VEHICLE ACCIDENT

_____
INSURANCE CARRIER'S NAME AND ADDRESS

_____TELEPHONE
CLAIM NUMBER

_____
DATE OF ACCIDENT CONTACT PERSON

_____

PLEASE READ CAREFULLY

INSURANCE INFORMATION

Health insurance is designed to help you meet the cost of medical services but the basic responsibility is yours. Your insurance contract defines to what extent the company can reimburse you. This may or may not completely cover our charges. Our services are offered on the basis that full charges will be paid by the regardless of insurance coverage. If you insurance is a plan with which Dr. LoVerme participates, the office will accept insurance according to that agreement. We urge you to be fully aware of the provisions of your policy, and if you have any questions, please contact your insurance company, personnel department, or union. If your insurance company does not pay your bill in full, you are responsible for the balance. Remember if you have a financial problem please let us know. If your insurance company needs additional information about your care to resolve your claim, we will supply them with this data. If you have not heard from your insurance company within a reasonable length of time (4 weeks) please contact them regarding the delay.

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with_____
Name of Insurance Company (ies)
and assign directly to Dr. LoVerme all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of the signature on all insurance submissions.

_____ _____ _____
Responsible Party Signature Relationship Date