BOAZ LISSAUER, MD MANHATTAN OCULOFACIAL PLASTIC SURGERY, PC
1036 park avenue new york, ny 10028 212.717.2150

**Date:** _____ **Social Security:** _____ **Birthdate:** _____
**Name**_____
LAST FIRST MIDDLE

**Address:** _____ **Apt#:** _____ **Home Phone:** _____
**City:** _____ **State:** _____ **Zip Code:** _____
**Sex: M** ❑ **F** ❑ **Minor** ❑ **Single** ❑ **Married** ❑ **Divorced** ❑ **Widowed** ❑
**Employer:** _____ **Business Phone:** _____
**Business Address:** _____ **Occupation:** _____

**Referring Physician:** _____**Referring Physician Phone:** _____
**Referring Physician Address:** _____
**In Case of an emergency, whom should we contact?** _____
**Phone:** _____**Relationship:**_____

**Primary Insurance:**

**Insurance Company Name:** _____ **Policy #:** _____
**Group #:** _____ **Insurance Company Address:** _____
**Person Responsible For Account:** _____ **Date of Birth:** _____
**Employer:** _____ **Social Security #:** _____
**Business Address:** _____ **Business Phone:** _____

**Secondary Insurance:**

**Insurance Company Name:** _____ **Policy #:** _____
**Group #:** _____ **Insurance Company Address:** _____
**Person Responsible For Account:** _____ **Birthdate:** _____
**Employer:** _____ **Social Security #:** _____
**Business Address:** _____ **Business Phone:** _____

**Medicare Beneficiary Signature on File**
**I authorize any holder of medical (or other) information about me to release it to the Social Security Administration and Healthcare Financing Administration, or their intermediaries, or carriers, or the billing agent of the above named medical practice, for the purposes of evaluating this or any related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment.**

**Signature**_____ **Date**_____

**Assignment and Release**
**I hereby authorize payment directly to Boaz J. Lissauer, M.D., P.C. for all insurance benefits otherwise payable to me for all services rendered. I understand that I am financially responsible for all charges, whether or not paid for by insurance, and for all services rendered on my behalf or that of my dependents. I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits, and I authorize the use of this signature on all insurance submissions.**

**Signature**_____ **Date**_____

**Patient Name:** _____

## Personal Medical History:

1. **When was your last physical exam?** _____
   **Physicians Name:** _____ **Phone:** _____
   **Physician's Address:** _____
2. **Are you currently under medical treatment? Yes ❑ No ❑**
   **Please describe:** _____
3. **Are you currently taking any medication? Yes ❑ No ❑**
   **Please list:** _____
4. **Have your ever had any serious illness or operations? Yes ❑ No ❑**
   **Please describe:** _____
5. **Do you smoke? Yes ❑ No ❑**
6. **Do you use alcohol, cocaine, or other drugs? Yes ❑ No ❑**
7. **Are you allergic to any of the following:**

| | | | |
|---|---|---|---|
| Antibiotics | Yes ❑ No ❑ | Local Anesthetics | Yes ❑ No ❑ |
| Aspirin | Yes ❑ No ❑ | Penicillin | Yes ❑ No ❑ |
| Barbiturates (sleeping pills) | Yes ❑ No ❑ | Sedatives | Yes ❑ No ❑ |
| Iodine | Yes ❑ No ❑ | Sulfa Drugs | Yes ❑ No ❑ |

8. **Have you ever had the following:**

| | | | | | |
|---|---|---|---|---|---|
| Anemia | Yes ❑ No ❑ | Heart Murmur | Yes ❑ No ❑ | Polio | Yes ❑ No ❑ |
| Arthritis | Yes ❑ No ❑ | Heart Disease | Yes ❑ No ❑ | Prostate Problem | Yes ❑ No ❑ |
| Asthma | Yes ❑ No ❑ | Hepatitis Type___ | Yes ❑ No ❑ | Psychiatric Care | Yes ❑ No ❑ |
| Back Problems | Yes ❑ No ❑ | Herpes | Yes ❑ No ❑ | Respiratory Disease | Yes ❑ No ❑ |
| Bleeding Tendency | Yes ❑ No ❑ | High Blood Pressure | Yes ❑ No ❑ | Shortness of Breath | Yes ❑ No ❑ |
| Blood Disease | Yes ❑ No ❑ | HIV/AIDS | Yes ❑ No ❑ | Sinus Trouble | Yes ❑ No ❑ |
| Cancer | Yes ❑ No ❑ | Kidney Disease | Yes ❑ No ❑ | Skin Condition | Yes ❑ No ❑ |
| Chemotherapy | Yes ❑ No ❑ | Liver Disease | Yes ❑ No ❑ | Stroke | Yes ❑ No ❑ |
| Circulatory Problem | Yes ❑ No ❑ | Low Blood Pressure | Yes ❑ No ❑ | Thyroid Problem | Yes ❑ No ❑ |
| Diabetes | Yes ❑ No ❑ | Migraine Headaches | Yes ❑ No ❑ | Tuberculosis | Yes ❑ No ❑ |
| Emphysema | Yes ❑ No ❑ | Mitral Valve Prolapse | Yes ❑ No ❑ | Ulcer | Yes ❑ No ❑ |
| Epilepsy | Yes ❑ No ❑ | Multiple Sclerosis | Yes ❑ No ❑ | Venereal Disease | Yes ❑ No ❑ |
| Glaucoma | Yes ❑ No ❑ | Pacemaker | Yes ❑ No ❑ | Other_____ | Yes ❑ No ❑ |

9. **Women ONLY:**
   **A.) Do you have regular periods?** Yes ❑ No ❑
   **B.) Are you taking birth control pills?** Yes ❑ No ❑
   **C.) Have you ever been pregnant?** Yes ❑ No ❑ **If yes, number of pregnancies** _____
   **D.) Are you pregnant now?** Yes ❑ No ❑

10. **Family Medical History:**
    **Please check off all that apply:**

| | Father | Mother | Brother | Sister | Other |
|---|---|---|---|---|---|
| Asthma | | | | | |
| Cancer | | | | | |
| Diabetes/Glaucoma | | | | | |
| Epilepsy | | | | | |
| Heart Disease | | | | | |
| High Blood Pressure | | | | | |
| Stroke | | | | | |

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**NOTICE OF PRIVACY PRACTICES and DISCLOSURE CONSENT**

**Federal Law precludes us from sharing information about your medical care (including treatment, payment, insurance, details etc.) without your written consent. You may revoke this authorization at anytime by notifying our practice in writing. Please indicate how you would like our practice to handle your medical information.**

**[ ] I authorize Manhattan Oculofacial Plastic Surgery, PC to disclose/discuss information regarding my treatment and billing or insurance issues to the following individual(s):**

**[ ] I do not authorize Manhattan Oculofacial Plastic Surgery, PC to disclose/discuss information regarding my treatment and billing or insurance with anyone other than myself.**

_____

**Patient Signature/Signature of Parent/Guardian/ Representative**

_____

**Today's Date**