GEORGE A. TOLEDO, M.D. P.A.
Highland Park Plastic Surgery Center

PATIENT INFORMATION

Patient's Legal Name

Cell Phone #

Address

Home Phone #

State

Zip

City

Age

Birthday MM/DD/YYYY

Marital Status S M W D

Sex Male Female

Driver's License #

Social Security #

Employer

Occupation

Business Address

Business Phone #

Whom May We Contact in an Emergency

Phone #

Who is Responsible For Your Bill

Patient's Email

Reason for Consultation

Referred By

MEDICAL INSURANCE

Primary Insurance Co. Name

Phone #

Insured Name

ID #

Group #

Insured Address

Insured SS#

Insured DOB

ASSIGNMENT OF INSURANCE BENEFITS & CONSENT TO PAY

The Undersigned hereby authorizes and consents to be seen and treated by Dr. George A. Toledo, in addition to the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the Undersigned had personally signed the particular claim. I also authorize payment on my claim, if any, to be made directly to George A. Toledo, M.D. and the Highland Park Plastic Surgery Center.

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered, and in the event of nonpayment to pay all costs of collection. I have completed the above questions and I certify this information is TRUE and CORRECT to the best of my knowledge. I will notify you of any changes in my health status or the above information.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

I acknowledge I have been presented with a copy of Notice of Privacy Practices for Protected Health Information.

PATIENT INFORMATION

Height ______ Weight ______

Do you or did you smoke? ☐ YES ☐ NO If Yes, please comment ______

Are you ALLERGIC to any drugs or medications? ☐ YES ☐ NO If Yes, please comment ______

Name of your MEDICAL DOCTOR ______ Phone # ______

When was your last complete physical exam? ______ Results ______

Name of your PHARMACY ______ Phone # ______

MEDICATIONS: List all medicines you are now taking (ex: birth control, diuretics (water pills), blood pressure or heart meds, tranquilizers, hormones, cortisone, blood thinners, aspirin, etc.) Include any diet pills, vitamins, herbal, or homeopathic products:

______

______

Question		
Have you ever had a REACTION to a GENERAL anesthetic (being put to sleep)	☐ YES	☐ NO
Have you ever had a REACTION to a LOCAL anesthetic (Novocaine, etc.)	☐ YES	☐ NO
Do you scar poorly?	☐ YES	☐ NO
Do you bruise easily or have difficulty stopping bleeding when cut?	☐ YES	☐ NO
Have you ever had any significant emotional problems or required psychiatric care?	☐ YES	☐ NO
Have you seen other Plastic Surgeons for your current problem?	☐ YES	☐ NO

MEDICAL ILLNESS: List all diseases or illnesses you have had (ex: high blood pressure, diabetes, heart or lung problems, etc.) and state how they are being treated:

______

______

INJURIES: Are you here today because of an accident? DATE ______ TYPE ______

PREVIOUS HOSPITALIZATION AND / OR SURGERY: (especially any type of COSMETIC surgery)

Year	Where	Why
Year	Where	Why
Year	Where	Why

MATERNAL HISTORY: How many children do you have? ______ Are you pregnant now? ______

FAMILY HISTORY: Has any family member had:

Heart Disease	Breast Cancer
High Blood Pressure	Melanoma
Diabetes	Other cancer

Any OTHER information which may assist us in your care:

______

I certify that all the above information is true and correct to the best of my knowledge.

SIGNATURE ______ DATE ______

WITNESS ______ DATE ______