ELSA RASKIN, M.D.
PLASTIC & COSMETIC SURGERY

Patient Information

Please print and answer all questions completely. If any of this information changes in the future, please let the office know. Thank you.

Patient Name_____ Today's Date _____

Street Address_____ City_____ State_____ Zip_____

Date of Birth _____ Age ____ Social Security #_____ Sex __M ___F

Phone Numbers: Home # _____Office #_____ Cell #_____

E-mail Address _____Marital Status_____Preferred Phone #: □home □cell

Emergency Contact _____ Relationship to Patient _____ Phone _____

Who is your Primary Care Doctor? _____ Phone #_____

How did you find out about our practice? □ Internet □ friend_____ □ other

If other, please explain: _____

Are you employed? ____ Yes ____ No What is your usual occupation? _____

Pharmacy Name_____ **Pharmacy Phone** _____

INSURANCE INFORMATION (if applicable)

Insurance 1_____ Policy Holder _____ Social Security #_____
Policy #_____Group # _____ Copay Amount _____
Employer responsible for insurance: _____ Phone _____
Address: _____

Do you have additional (secondary) insurance? Insurance 2: _____ Policy Holder _____
Policy #_____ Group #_____

GUARANTOR INFORMATION
(The guarantor is the person responsible for the patient's finances: for example, parent, spouse or the actual patient.)
Is the guarantor the patient? ___Yes ___No (If no, please fill in the information below for the Guarantor.)

Name _____ Relationship to Patient _____
Street Address _____ City _____ State _____ Zip _____
Social Security #_____ Birthdate _____ Phone: (W) _____ (H) _____

I authorize release of any medical information necessary to process any insurance claims. I authorize payment of medical benefits directly to the physician or supplier of services for myself and/or dependents. I understand I am responsible for any deductibles, co-insurances, or amounts for services not covered by the insurance carrier. I also understand that it is my responsibility to obtain the necessary referrals for my visits and medical care, and to verify that my insurance is active and up to date. I also give consent to the taking of photographs for the medical record or teaching purposes, as long as the identity of the patient is not revealed. This authority shall remain outstanding until withdrawn in writing by the undersigned.

Signature _____ Date _____
(Patient or Guardian)

MEDICAL INFORMATION

Why have you come to see Dr. Raskin? _____

Height _____ Weight _____

List all **ALLERGIES/**reactions to medications

_____

List all **MEDICATIONS** taken on a regular basis

_____

Aspirin __ Pain Medication __ Blood Thinner __ Insulin __ Anti-inflammatory (Advil) ___ Vitamin E_____

Have you ever taken **STEROIDS**? ___Yes ___No type:_____

Have you ever **SMOKED**? ___ Yes ___ No What _____? How much? _____ Quit Date _____

Do you drink **ALCOHOL**? ___ Yes ___ No How much _____How often _____ Quit Date_____

List medical problems you have or have had in the past _____

Please list all surgeries you have had and when they took place: _____

_____

Have you ever had a problem with anesthesia? ___Yes ___ No. If yes, describe_____
Number of pregnancies ____ Age at last pregnancy ____ Have you had a C-Section? ___ Yes ___ No

Pleases check any of the following which you have or have had in the past:

___High Blood Pressure	___Chest Pain	___Connective Tissue Disease	___Cold Sore
___Heart Attack	___Tuberculosis	___Shortness of Breath	___Skin Cancer
___Arrhythmia	___Liver Disease	___Chemical Peel/Retin A	___Ulcers
___Blood Clot	___Thyroid Disorder	___Unexplained weight loss	___Stroke
___Diabetes	___Night Sweats	___Keloid/Hypertrophic scar	___Arthritis
___Joint Replacement	___Rheumatic Fever	___Reynaud's Disease	___Psychiatric
___Heart Valve Problem	___Bone/Joint Disease	___Skin Rash or Problem	___Gout
___Nerve Problem	___Cancer	___Hepatitis	___Transfusion
___Aids or HIV+	___Herpes/Zoster	___Bruise easily; gums bleeding	

Circle if your relatives are alive (A) or deceased (D) and list any medical problems they had:

Mother (A/D) _____
Father (A/D) _____
Children (A/D) _____
Brothers (A/D) _____
Sisters (A/D) _____
Aunts (A/D) _____
Uncles (A/D) _____
Maternal Grandmother (A/D) _____
Maternal Grandfather (A/D) _____
Paternal Grandmother (A/D) _____
Paternal Grandfather (A/D) _____