

FREDERICK J. MENICK, M.D.
Diplomat of the American Board of Plastic Surgery

Welcome to our Office

Date: _____

Patient Information

Last Name: _____ First Name: _____ M.I. _____

Address: _____ City: _____ ST _____ Zip _____

Home# _____ Work# _____ Alt.# _____

Social Security# _____ D.O.B. ____/____/____ (Age ____) Male or Female

Patient Status: ()-single ()-married ()-separated ()-divorced ()-widowed ()-other

Employer Name _____ Phone# _____

Address: _____ City: _____ ST _____ Zip _____

Reason for Visit? _____

How were you referred to Dr. Menick? Yellow Pages ____ Dex online ____ Internet ____ Friend ____

Dr. Menick's website ____ Physician/name _____ Other _____

Emergency Contact: Name _____ phone # _____

E-mail Address: _____

Authorization to release information and assignment of benefits: I hereby authorize Dr. Menick to release any medical information necessary to process my claim(s) to my insurer, and also authorize payment to be made directly to Frederick J. Menick, M.D.

Consent to be photographed: I consent to the photographing of my pre-operative, operative and post-operative condition and the procedures performed. This material may be used for medical, and professional activities, including the INTERNET to provide information and educational materials to medical professionals and the public. I am over 18 years of age.

Patient Signature _____ Date _____

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Insurance Information

Primary Insurance

Insurance Company: _____ Ins. Effective Date: _____

Policy Holder's Name: _____
Last MI First

DOB: ____/____/____ SSN #: _____ - _____ - _____ Sex: M or F

Employer: _____

Policy ID #: _____ Group #: _____

Relationship to Patient: Self Spouse Parent Guardian

Secondary Insurance (if applicable)

Insurance Company: _____ Ins. Effective Date: _____

Policy Holder's Name: _____
Last MI First

DOB: ____/____/____ SSN #: _____ - _____ - _____ Sex: M or F

Employer: _____

Policy ID #: _____ Group #: _____

Relationship to Patient: Self Spouse Parent Guardian

Medical History

Patient Name _____ Today's Date _____

Past Medical History/ Review of Systems (do you currently have or have you ever had any of the following)

Skin

- atypical moles(nevi)
- pre-cancer lesions
- basal cell carcinoma
- squamous cell carcinoma
- melanoma
- abnormal scarring/keloids
- other _____
- NORMAL

Musculoskeletal

- artificial joints
- arthritis
- muscle weakness
- fibromyalgia
- other _____
- NORMAL

Neurological

- stroke
- seizure (epilepsy)
- neuralgia
- numbness/tingling
- other _____
- NORMAL

Cardiovascular

- high blood pressure
- chest pain
- heart attack
- pacemaker
- artificial heart valve
- other _____
- NORMAL

Respiratory

- asthma
- emphysema
- cough
- other _____
- NORMAL

Gastrointestinal

- stomach ulcer
- colitis
- liver problems
- other _____
- NORMAL

Hematologic/Lymphatic

- anemia
- bleeding problems
- enlarged lymph nodes
- other _____
- NORMAL

Eye/Ear/Nose/Throat

- glaucoma
- hearing aid
- plastic surgery
- other _____
- NORMAL

Psychiatric

- depression
- anxiety
- dementia
- other _____
- NORMAL

Endocrine

- diabetes
- thyroid
- oral steroid use
- other _____
- NORMAL

Infections

- hepatitis A, B, C
- HIV / AIDS
- tuberculosis / TB
- other _____
- NORMAL

Urologic

- dialysis
- kidney problems
- venereal disease
- other _____
- NORMAL

Immune

- lupus
- organ transplant
- cancer chemotherapy
- other _____
- NORMAL

Constitutional

- weight loss
- fever
- chills
- other _____
- NORMAL

- Are you currently pregnant, planning to become pregnant, or nursing?..... Yes No
- Does your Dentist ask you to take Antibiotics before dental work?..... Yes No
- Are you allergic to latex?..... Yes No
- Do you routinely wear sunscreen?..... Yes No
- History of MRSA or VRE? Yes No

Surgeries (skin cancer and all surgeries): _____

Hospitalizations/ other Illnesses: _____

Medications (Include over the counter meds. and vitamins): _____

Allergies (medications, food): _____

Social History: Tobacco Use: No ___ Yes ___ (age started ___ amount per day ___ age quit ___ currently using ___)
Alcohol: No ___ Yes ___ (amount per day/week _____)

Family History (blood relatives only list relationship to you):

- skin cancer
 - other skin problems
 - other medical problems
 - none known
- _____

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Acknowledgment of Receipt of Privacy Notice
Original to be maintained in patient's permanent medical record

I acknowledge that I have received a copy of the office's Notice of Privacy Practices

Patient or legally authorized individual signature

Date

Printed name if signed on behalf of the patient

Relationship (parent, legal guardian,
personal representative, etc.)