Cosmetic & Reconstructive Surgery
ASSOCIATES OF CONNECTICUT

Today's Date: ____/____/_____

GENERAL INFORMATION

Name:[first,last]_____

Name of parent/guardian (if under 18 years):
_____

Birth date: _____/_____/_____ Age: _____ Gender: Male_____ Female_____

Address:_____[Apt #]_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Mobile:_____ Work:_____

Email:_____ Marital Status: Single____ Married____ Other:_____

Height:_____ Weight:_____ BMI:_____

EMERGENCY CONTACT

Name:_____ Relationship:_____

Home Phone:_____ Mobile:_____ Work:_____

EMPLOYMENT INFORMATION

Full-time_____ Part-time_____ Student_____ Other_____ Occupation_____

Employer: _____ Work Phone: _____

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INSURANCE INFORMATION

Primary Insurance:_____

Self_____ Spouse____ DOB___/___/___ Parent_____ DOB___/___/___

Name of Insured: [first, last]_____

Policy Number:_____ Group Number: _____

Secondary Insurance:_____

Self_____ Spouse____ DOB___/___/___ Parent_____ DOB___/___/___

Name of Insured: [first, last]_____

Policy Number:_____ Group Number: _____

PRIMARY CARE PHYSICIAN

Name: _____ Phone: _____

Location: _____

**** Please provide insurance cards and driver's license or ID****

The information above is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible

for the balance. I also authorize Cosmetic and Reconstructive Surgery Associates of CT or insurance company to release any information required to process my claims.

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PAST MEDICAL HISTORY
(check all that apply)

___ Not Applicable
___ Anxiety
___ Arthritis
___ Asthma
___ Blood Disorders
___ Bone Pain
___ Breast Cancer
___ Cancer Type:_____
___ Cardiac disease
___ Depression
___ Diabetes
___ Dry Eye
___ DVT
___ High blood pressure
___ High cholesterol
___ HIV/AIDS
___ Kidney Disease
___ Liver Disease
___ Kidney Stones
___ Neuropathy
___ Orthopedic
___ Other:_____
___ Pacemaker
___ Peripheral Vascular Disease
___ Polycystic Ovarian Syndrome
___ Pressure Ulcer
___ Psychiatric Diagnosis
___ Seasonal Allergies
___ Seizures
___ Skin Disease
___ Stroke
___ Thyroid Disorder
___ Tuberculosis
___ Ulcers

FAMILY HISTORY
(check all that apply)

___ Not Applicable
___ A. Fib
___ Abnormal Bleeding
___ Abnormal Clotting
___ Anesthesia Problems
___ Anxiety/Depression
___ Autoimmune Disorder
___ Brain Tumor
___ Celiac Disease
___ Cleft Lip
___ Cleft Palate
___ Diabetes
___ Drug Allergies
___ Heart Disease
___ Hemophilia
___ High Blood Pressure
___ High Cholesterol
___ Kidney Disease
___ Liver Disease
___ Lymphoma
___ Malignant Hyperthermia
___ Osteoporosis
___ Other:_____
___ Rheumatoid Arthritis
___ Skin Disease
___ Stroke
___ Endocrine Disease
___ Hearing Loss
___ Substance Abuse
___ Thyroid Disease

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Please List Past Surgical History:

1. _____ Date: ____/____/____
2. _____ Date: ____/____/____
3. _____ Date: ____/____/____
4. _____ Date: _____/_____/___

Please List Allergies to Medications:

1. _____
2. _____
3. _____
4. _____

Please List Current Medications:

1. _____ Dosage: _____
2. _____ Dosage: _____
3. _____ Dosage: _____
4. _____ Dosage: _____

SOCIAL HISTORY

Have you ever smoked tobacco products? (Current, Former, Never)

Do you drink alcohol? Yes (everyday/occasional/ rare) No

REFERRAL INFORMATION

Referring Physician or Patient: _____

How did you hear about Dr. Melendez?_____

PROCEDURE INFORMATION

Reason For Visit? _____

_____

Surgery Scheduling Questionnaire:

To help us understand your particular needs and time preferences for your surgery, please provide us with the following information:

What is your time preference for your procedure?

Within the next: _____ Month _____ 3 Months _____ 6 Months _____ 1 Year

Do you prefer: _____ Morning _____ Evening

**** Verification: All information provided above is accurate and complete to the best of your my knowledge.**

Patient Signature: _____Date: ____/_____/_____

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CONSENT SIGNATURE FORM

I do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

_____ _____

Signature of Patient or Guardian **Date**

I consent to being photographed as part of the overall plan and evaluation for any future surgery. These photographs will be property of CRSA of CT.
I also authorize the physician to release any information/photographic material required for didactic (teaching), medical and payment purposes.
I understand that these photographs will be used in such a way as to conceal my identity.

_____ _____

Signature of Patient or Guardian **Date**

I accept full responsibility for payment of all services rendered by Mark Melendez, M.D. at CRSA of CT and authorize my insurance benefits to be paid directly to his office, when applicable. Additionally, I agree to pay all costs of collection, including reasonable attorney's fee.
Please be aware Dr. Melendez may not be in-network with your insurance company. It is your responsibility to inquire about your out-of-network benefits.

_____ _____

Signature of Patient or Guardian **Date**