JERALD R. SULTZ, M.D.
PLASTIC SURGERY

Phone: 716-634-1970 • Fax: 716-634-3845
Website: www.sultzmd.com

PATIENT INFORMATION - Please Print Legibly

Name			Date	
Address		City	State	Zip Code
Home Phone	Cell Phone		Work Phone	
Birth Date	Age	Sex	Occupation	
Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Widowed			E-mail Address	
Person to Contact in an Emergency	Phone		How did you hear about us? ❑ Advertising ❑ Physician Referral ❑ Friend / Family	

PHARMACY INFORMATION

Pharmacy Name			
Phone			
Address	City	State	Zip Code

INSURANCE INFORMATION

If a Minor - Who Assumes Financial Responsibility?

Primary Insurance Company			Secondary Insurance Company	
Group #	Policy #		Group #	Policy #
Name of Subscriber	DOB of Subscriber		Name of Subscriber	
Relationship to Patient			Relationship to Patient	

1. AUTHORITY TO TAKE PHOTOGRAPHS: I give my permission to Dr. Jerald R. Sultz, to take photographs as indicated by him. I understand that these photos are clinical documents and may be used by him for scientific purpose as he sees fit.

2. ASSIGNMENT OF BENEFITS - CONSENT FOR TREATMENT - RELEASE INFORMATION: I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and any other plan. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges *whether or not paid by said insurance.* I hereby authorize said assignee to release all information necessary to secure the payment. I hereby authorize Dr. Jerald R. Sultz, his associates and assistants to perform any medical/surgical treatment or procedure as deemed necessary.

(Patient Signature) (Patient's Printed/Typed Name) Dated:

In the following questions, circle yes or no, whichever applies.

1. What is the reason for today's visit?_____

2. Primary Physician Name and Address? _____

3. Date of your last physical examination _____

4. Have you ever had any surgery; e.g. tonsillectomy, appendectomy, etc.? ..... YES NO

   Operation and date:_____

   _____

   _____

5. Have you ever had or have asthma, cancer, circulation problems, diabetes, heart attack, heart disease, hepatitis, HIV, high blood pressure, kidney trouble, mental illness/depression or thyroid problems? (Circle any that apply.) ..... YES NO

6. Do you have any disease, condition, or problem not listed above? ..... YES NO

   _____

   _____

7. Are you taking any drug or medicine?..... YES NO

   List any and all medications, (including birth control pills) and dosages

   _____

   _____

   _____

8. Do you take aspirin, Advil, Aleve, Motrin or Ibuprofen? How much and how frequently?_____ YES NO

9. Do you take vitamins or fish oil, vitamin E or other supplements? Which ones?_____ YES NO

10. Do you have any allergies (anesthetics, antibiotics, etc.)?..... YES NO

    Others_____

11. Do you smoke? If so, how much?_____ YES NO

12. Any family history of diabetes, cancer, heart disease, breast disease, melanoma?..... YES NO

    Who?_____

13. Women

    A. Do you have any children?..... YES NO

    B. Are you pregnant?..... YES NO

    C. Do you have a history of breast disease? ..... YES NO

    D. Date of last mammogram? ..... YES NO

I AFFIRM THAT ALL OF THE ABOVE INFORMATION IS ACCURATE

SIGNATURE_____ **DATE**_____

Name: _____ **Today's Date:** _____

REVIEW OF SYSTEMS

For new patients, established patients who may be having a new problem, or our patients who we haven't seen for a while, we need to update our records as to your general medical health. In each area, if you are not having any difficulties, please check "No Problems." If you are experiencing any of the symptoms listed, **PLEASE CIRCLE THE ONES THAT APPLY**, or explain any that may not be listed. If you have any questions about this, please ask one of the technicians, or your doctor.

Const. (Health in General) ❑ No Problems Lack of energy, unexplained weight gain or weight loss, loss of appetite, fever, night sweats, pain in jaws when eating, scalp tenderness, prior diagnosis of cancer. Other: _____

Ears, Nose, Mouth & Throat ❑ No Problems Difficulty with hearing, sinus problems, runny nose, post-nasal drip, ringing in ears, mouth sores, loose teeth, ear pain, nosebleeds, sore throat, facial pain or numbness. Other: _____

C-V (Heart & Blood Vessels) ❑ No Problems Irregular heartbeat, racing heart, chest pains, swelling of feet or legs, pain in legs with walking. Other: _____

Resp. (Lungs & Breathing) ❑ No Problems Shortness of breath, night sweats, prolonged cough, wheezing, sputum production, prior tuberculosis, pleurisy, oxygen at home, coughing up blood, abnormal chest x-ray. Other: _____

GI (Stomach & Intestines) ❑ No Problems Heartburn, constipation, intolerance to certain foods, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, unexplained change in bowel habits, incontinence. Other: _____

GU (Kidney & Bladder) ❑ No Problems Painful urination, frequent urination, urgency, prostate problems, bladder problems, impotence. Other: _____

MS (Muscles, Bones, Joints) ❑ No Problems Joint pain, aching muscles, shoulder pain, swelling of joints, joint deformities, back pain. Other: _____

Integ. (Skin, Hair & Breast) ❑ No Problems Persistent rash, itching, new skin lesion, change in existing skin lesion, hair loss or increase, breast changes. Other: _____

Neurologic (Brain & Nerves) ❑ No Problems Frequent headaches, double vision, weakness, change in sensation, problems with walking or balance, dizziness, tremor, loss of consciousness, uncontrolled motions, episodes of visual loss. Other: _____

Psychiatric (Mood & Thinking) ❑ No Problems Insomnia, irritability, depression, anxiety, recurrent bad thoughts, mood swings, hallucinations, compulsions. Other: _____

Endocrinologic (Glands) ❑ No Problems Intolerance to heat or cold, menstrual irregularities, frequent hunger/urination/thirst, changes in sex drive. Other: _____

Hematologic (Blood/Lymph) ❑ No Problems Easy bleeding, easy bruising, anemia, abnormal blood tests, leukemia, unexplained swollen areas. Other: _____

Allergic/Immunologic ❑ No Problems Seasonal allergies, hay fever symptoms, itching, frequent infections, exposure to HIV. Other: _____

JERALD R. SULTZ, M.D.

Certified by The American Board of Plastic Surgery

Notice of Privacy Practices
Patient Acknowledgment

Patient Name _____

Date of Birth _____

I have received and understand this practice's Notice of Privacy practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices and to make changes regarding all protected health information resident at or controlled by this practice. If changes to the policy occur, this practice will provide me a revised Notice of Privacy Practices upon request.

I wish to allow Dr. Sultz and/or his staff release information about me to the following persons:

_____

Signature _____

Date _____

Relationship to patient if signed by representative of that patient

_____

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NOTICE OF FINANCIAL RESPONSIBILITY AND WAIVER

Dear Patient,

Positive verification of your insurance coverage cannot always be made at the time of service. You will receive services with the understanding that in the event your coverage is not in effect or services have been denied for lack of benefits or referral, you may be billed and held financially responsible for the services rendered. Please note that we do not participate in Aetna, Cigna, Medicaid or Fidelis insurance plans among others.

If you have chosen a high deductible plan for your insurance coverage, this means that you must meet a certain, pre-determined amount of out of pocket expense before your insurance will cover any of your healthcare costs. After you have met your deductible, you may only be responsible for co-payments. Questions concerning your deductible should be directed to your insurance company as every contract is unique.

If you have not met your deductible at the time of your appointment, you will be asked to pay for the appointment at the time of service. Should you require surgery, you will be billed after the procedure. While we can provide you with an estimate of the surgery, we cannot guarantee what your financial responsibility will be.

If for any reason you maintain an unpaid balance on your account and fail to work out a payment arrangement with us, after 90 days your account may be turned over to a collection agency and proceedings may begin. Accounts sent to collections will have a collection fee and lawyer's fees added to the balance.

If you have any questions about this policy, please contact the office.

I have read the above disclosure and understand my possible financial responsibility for services rendered. I agree to all of the above policies. I understand that my failure to comply with any of these policies may result in discharge from the medical practice.

Signature_____

Date_____

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