JONATHAN L. LEBOWITZ, M.D. P.C.

REGISTRATION (PLEASE PRINT CLEARLY) TODAY'S DATE: _____

FIRST NAME: _____ MIDDLE INITIAL: _____ LAST NAME: _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____

HOME PHONE: _____ CELL: _____ E-MAIL: _____

SEX: M / F DATE OF BIRTH: _____ SSN: _____ MARITAL STATUS: _____

M.D./PEDIATRICIAN: _____ REFERRING DR. _____

IF PATIENT IS MINOR/DEPENDENT: FATHER'S NAME: _____ MOTHER'S NAME: _____

PRIMARY INSURANCE COMPANY: _____ POLICY ID#: _____

GROUP #: _____ POLICY HOLDER NAME: _____ DOB: _____

ADDRESS: (IF DIFFERENT THAN ABOVE) _____ SSN: _____

YOUR RELATIONSHIP TO POLICY HOLDER: SELF/SPOUSE/CHILD/OTHER EMPLOYER: _____

SECONDARY INSURANCE COMPANY: _____ POLICY ID#: _____

GROUP #: _____ POLICY HOLDER NAME: _____ DOB: _____

ADDRESS: (IF DIFFERENT THAN ABOVE) _____ SSN: _____

YOUR RELATIONSHIP TO POLICY HOLDER: SELF/SPOUSE/CHILD/OTHER

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES FOR SERVICES RENDERED TO ME, INCLUDING THE BALANCE REMAINING AFTER PAYMENT OF POSSIBLE INSURNACE BENEFITS.

ASSIGNMENT OF BENEFITS: I REQUEST THAT PAYMENT OF THE AUTHORIZED BENEFITS BE PAID ON MY BEHALF TO JONATHAN L. LEBOWITZ, M.D. FOR SERVICE RENDERED BY THIS OFFICE.

RELEASE INFORMATION: I HEREBY AUTHORIZE ANY PHYSICIAN, MEDICALLY RELATED FACILITY OR INSURANCE COMPANY TO FURNISH ANY AND ALL RECORDS, PHOTOGRAPHS, AND/OR MEDICAL HISTORY FOR SERVICES/TREATMENT RENDERED TO MYSELF OR DEPENDENT FOR THE PURPOSES OF REVIEW, INVESTIGATIONS OR EVALUATION OF ANY CLAIM SUBMITTED TO INSURER.

SIGNED (PATIENT OR PARENT, IF MINOR): _____ DATE: _____

JONATHAN L. LEBOWITZ, M.D., P.C.

Plastic Surgeon

PATIENT HEALTH INFORMATION

PATIENT NAME: _____ DOB: _____ AGE: _____

OCCUPATION: _____ REASON FOR VISIT: _____

_____

LIST ALL ALLERGIES TO MEDICATIONS, SUBSTANCES, TAPE/LATEX/ADHESIVE: _____

_____

LIST ALL MEDICATIONS/ VITAMINS YOU ARE CURRENTLY TAKING: _____

_____

_____

LIST ANY MEDICAL CONDITIONS FOR WHICH YOU ARE PRESENTLY BEING TREATED FOR:

_____

_____

IS THIS VISIT DUE TO AN INJURY, IF SO WHEN AND HOW: _____

_____

LIST ALL PAST SURGERIES WITH DATES: _____

_____

_____

DID YOU EVER HAVE ANY COMPLICATIONS FROM SURGERY, IF SO WHAT? _____

_____

_____

CURRENT/PAST HEALTH PROBLEMS:

CANCER	NO	YES	SKIN CANCER	NO	YES
EAR/NOSE/THROAT/MOUTH	NO	YES	EYES	NO	YES
HIGH BLOOD PRESSURE	NO	YES	HEART	NO	YES
LUNGS	N0	YES	LIVER DISEASE	NO	YES
ARTHRITIS/MUSCLES/JOINTS	NO	YES	STOMACH/BOWEL	NO	YES
HEADACHES/SEIZURES	NO	YES	KIDNEYS	NO	YES
OTHER (I.E. DIABETES, LUPUS ETC)	NO	YES	BLOOD DISORDER	NO	YES

IF YES, PLEASE EXPLAIN: _____

_____

_____

JONATHAN L. LEBOWITZ, M.D., P.C.

PLASTIC SURGEON

29 Green Street
Huntington, New York 11743

(631) 424-0101

Dear Patient:

Please read the following responses to the most often asked questions prior to a surgical procedure:

DISCOMFORT:

There will be some discomfort when the anesthetic is injected at the surgical site. Post-operatively you may have some initial discomfort. Pain varies with the individual and with the surgical area. Let Dr. Lebowitz know if you have pain that concerns you.

SCAR:

You will have a scar at the surgical site. It may be initially red and swollen, but eventually will fade (after about six months). However, some areas like the back and chest do scar more. Everyone heals differently and variations do occur.

INFECTION:

This is a possibility with any surgery. Dr. Lebowitz will prescribe an antibiotic if indicated and/or see you more often in follow-up visits if he sees the need.

SUTURES:

You will definitely have stitches. Some will be self absorbing and some may or may not need to be removed. Dr. Lebowitz determines these at the time of surgery.

FOLLOW-UP:

Dr. Lebowitz is a Plastic Surgeon and most of the time you will only need one post-op visit. However, there are times when he will need to see you more often. It is very important to keep these appointments.

INSTRUCTIONS:

At the completion of surgery you will be given a post-op instruction sheet. The instructions given are specifically for you and must be adhered to. Please read carefully and do as instructed.

Please remember that Dr Lebowitz is available to you 24 hours a day, seven days a week. If you have any problem or do not understand your instructions please call our office.

I have read and understand all the details of my surgery as outlined above.

_____	_____	_____
Patient (Guardian) Signature	Date	Witness