**SOMERSET PLASTIC SURGERY**

**MICHAEL J. BUSUITO, MD [ ✓ ] MICHAEL S. MEININGER , MD [ ] PRAVIN P PURI, MD [ ]**

**Print Legibly**

**Patient's Name:** Last:_____ First:_____ MI:_____

Address _____
Street & Apt # City State Zip

Age _____ Birthdate____/____/_____ SS#: _____-_____-_____ Sex ☐ Female ☐ Male

☐ Single ☐ Married Spouse: _____ ☐ Other _____

Home #: _____[ ]Cell #: _____[ ]Other # _____[ ] Please [ ✓ ]preferred contact #

E-mail _____ Driver's License #: _____ State _____

**Emergency Contact** _____ Relationship to Pt: _____
(Not in your household)

Phone # _____ Address: _____

**Patient's Employer** _____ Occupation_____

Work Phone _____Ext: _____ Is it okay to call you at work? ☐ No ☐ Yes

**Spouses Employer** _____ Occupation_____

**RACE: ☐ White/Caucasian ☐ Black/African American ☐ Asian ☐ Hispanic ☐ Other_____ LANGUAGE: ☐ English ☐ Spanish ☐Other_____**
**Race is a federal requirement mandated by CMS-Centers for Medicare & Medicaid Services – Appropriate Box(s) must be marked**

**Referred By:** _____

Phone # _____ Address: _____

**Primary Care Physician** _____

Phone # _____ Address: _____

**Primary Health Insurance Company:**_____

Policy #: _____Group #: _____ Copay? ☐ No ☐ Yes $_____ Referral Required? ☐ No ☐ Yes

**Subscriber:** Name: _____ DOB: ____/___/____ Subscriber SS#: _____-_____-_____

**Secondary Health Insurance Company** _____

Policy #: _____Group #: _____ Copay? ☐ No ☐ Yes $_____ Referral Required? ☐ No ☐ Yes

**Subscriber:** Name: _____ DOB: ____/___/____ Subscriber SS#: _____-_____-_____

**Authorization to pay benefits to physician and release of medical information:** I hereby authorize payment directly to Michael J. Busuito, M.D., of any surgical and/or medical benefits otherwise payable to me for his services. I hereby authorize Dr. Busuito to release any medical information necessary for payment on my insurance claim. I understand I am responsible for payment of all copays and deductibles as required by my insurance company.

**Signature** _____ **Date** _____

# SOMERSET PLASTIC SURGERY
# HEALTH HISTORY FORM

**MICHAEL J. BUSUITO, MD [✓]** **MICHAEL S. MEININGER , MD [ ]** **PRAVIN P PURI, MD [ ]**

Check Physician Box

NAME: _____ ☐ Female ☐ Male
Last First Middle

AGE: _____ DATE OF BIRTH: _____/_____/_____ HEIGHT _____ WEIGHT _____

**Reason for your visit today:** _____

**PAST MEDICAL CONDITIONS:** ☑ appropriate boxes below

- ☐ No Past Medical History
- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anesthesia Problems
- ☐ Autoimmune Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Breast Cancer
- ☐ Cancer _____ Type
- ☐ Chest Pain/Tightness
- ☐ Depression/Anxiety
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Heart Murmur
- ☐ Healing Problems _____
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Pacemaker
- ☐ Post Radiation Therapy
- ☐ Psychiatric Care
- ☐ Skin Cancer
- ☐ Stroke
- ☐ Substance Abuse
- ☐ Thyroid Problem
- ☐ Tuberculosis
- ☐ Transfusion _____ Date

Other_____

**FEMALES ONLY:**

- ☐ Fibrocystic Breasts
- ☐ BRCA Gene Positive
- ☐ Going Through Menopause
- ☐ Ovarian Cancer

Plan Becoming Pregnant? Y [ ]N[ ]
# Pregnancies_____
# Live Births_____
Ages of Children: _____
Currently Pregnant: Y [ ]N [ ]
Last Mammogram
Normal:Y [ ]N [ ]_____ Date:

**MEDICATIONS:** Attach Sheet if more room is needed
**ARE YOU TAKING ASPIRIN Y [ ] N [ ] Dose_____**

| Drug Name | Dose | Frequency |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

Pharmacy: Phone#:
Address:

**ALLERGIES: LATEX Y [ ] N [ ]**
**Please List All Medication/Substance Allergies_____**

**SURGICAL HISTORY** List any surgeries/ hospitalizations

| Description | Year |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

**FAMILY HISTORY:** ☑ If applicable

- ☐ Breast Cancer – Who:_____
- ☐ Diabetes
- ☐ Heart Disease/Stroke
- ☐ High Blood Pressure
- ☐ Hemophilia
- ☐ Malignant Hypothermia/Hyperthermia
- ☐ Ovarian Cancer
- ☐ Skin Cancer
- ☐ Abnormal Bleeding; Abnormal Clotting
- ☐ Other:_____

**SOCIAL HISTORY: SOCIAL HISTORY:** ☑ If applicable

Smoking Y [ ] N [ ] #Packs per day: _____ Alcohol Y [ ] N [ ] #Drinks per Wk:_____ Substance Abuse: Y [ ] N [ ] Caffeine Y [ ] N [ ]

I certify that the above information is correct to the best of my knowledge. I will not hold Dr. Busuito responsible for any omissions/errors I have made in completing this form. This information is confidential and will not be released without consent.

Signature:_____ Date:_____ Reviewed by: _____ Date: _____