ANNE M. NICKODEM, M.D., P.C., F.A.C.S.

Aesthetic, Breast, and Reconstructive Surgery

NEW PATIENT FORM

1. PATIENT DEMOGRAPHICS

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

Date of Birth: _____

Street Address: _____

Apt/Suite: _____ **City:** _____ **State:** _____ **Zip:** _____

Cell Phone: _____ **Home Phone:** _____ **Email:** _____

Referred By: _____ **Reason for Consultation:** _____

2. CLINICAL MEASUREMENTS & ALLERGIES

Height: _____ **Weight:** _____ **Latex Allergy:** ☐ Yes ☐ No

Allergies: _____

3. CURRENT MEDICAL CONDITIONS

☐ Anemia	☐ Depression	☐ Malignant Hyperthermia
☐ Arthritis	☐ Diabetes	☐ Migraines
☐ Asthma	☐ Glaucoma	☐ Pneumonia
☐ Bleeding Disorders	☐ Heart Disease	☐ Seizure Hx
☐ Blood Clots	☐ High Blood Pressure	☐ Skin Disorders
☐ Bronchitis	☐ Hiatal Hernia	☐ Stroke
☐ Cancer	☐ Kidney Disease	☐ Thyroid Disease
☐ Current/Past Pregnancy	☐ Liver Disorders	☐ Ulcers / Vascular Disease

Any history of depression or other mental health disorders? ☐ Yes ☐ No

If yes, please explain briefly: _____

Do you use Cigarettes, Vaping Products, Illicit Drugs, or Alcohol? ☐ Yes ☐ No

Women Only: Have you or are you currently going through menopause? ☐ Yes ☐ No ☐ N/A

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FORM 1: NEW PATIENT INTAKE PACKET

4. SURGICAL HISTORY & PRIOR HOSPITALIZATIONS

SURGICAL PROCEDURE OR REASON FOR HOSPITALIZATION	APPROX. DATE	ANESTHESIA REACTION / NOTES

5. MEDICATIONS (PRESCRIBED & OVER-THE-COUNTER)

Preferred Pharmacy: _____ **Phone/Loc:** _____

MEDICATION NAME	DOSAGE & FREQUENCY	REASON FOR TAKING

6. INSURANCE & CARE PROVIDER INFORMATION

Primary Ins Co: _____ **Subscriber Name:** _____

Policy ID #: _____ **Group Number:** _____

Subscriber DOB: _____ **Claims Address:** _____

Primary Doctor: _____ **Practice Name:** _____

7. OFFICE POLICIES & AUTHORIZATIONS

PAYMENT POLICY

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance with our office. In the event my account is turned over to an attorney for collections, I will pay any fee/cost incurred during the collection process.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize, Anne M. Nickodem MD, PC to furnish information to insurance carriers (including Medicare/Medigap) concerning my illness and treatments and I hereby assign to the physician all payments for medical services rendered for myself or my dependents. I understand that I am responsible for any amounts not covered by insurance.

I certify that the information I have provided above is accurate and correct to the best of my knowledge.

Signature of Patient or Guardian: _____ **Date:** _____