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

Aesthetic, Breast, and Reconstructive Surgery

RETURNING PATIENT

1. PATIENT IDENTIFICATION & VERIFICATION

Patient Name: _____ **Date of Birth:** _____

Today's Date: _____ **Date of Last Visit:** _____

Reason for Visit: _____

Address Change? ☐ Yes ☐ No

If yes, current address: _____

2. ALLERGIES & CLINICAL MEASUREMENTS

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

Allergies: _____

3. MEDICAL HISTORY

Please check all current or past 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

Hospitalizations, surgeries, or interims since last visit? ☐ Yes ☐ No

If yes, list starting at most recent: _____

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FORM 2: RETURNING PATIENT PATIENT PACKET

4. MEDICATIONS

Please list all current prescription and over-the-counter medications:

MEDICATION NAME	DOSAGE & FREQUENCY	REASON FOR TAKING

5. INSURANCE & CARE PROVIDER INFORMATION

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

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

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

6. 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:** _____