PATIENT INTAKE FORM

CRAIG BALDENHOFER MD

Date:_____

Patient Name: (Last) _____ (First) _____(M)_____

Permanent Address: _____City _____State_____ Zip _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____ ☐ Text Opt In

Date of Birth: _____ Age: _____Sex: M F Email: _____

Social Security: _____Drivers License: _____
(If Using Insurance) *(If Using Insurance)*

Employer: _____Occupation:_____

In case of emergency, contact: _____Relationship: _____Phone: _____

How did you hear about us? _____ Marital Status: _____

Pharmacy: _____Address: _____ Phone: _____

If we are billing your insurance company please complete the following:

Primary Insurance Co: _____ Insurance Phone: _____Policy #:_____

Group #: _____ Employer: _____

Policy Holder's Name: _____ DOB: _____ SSN:_____

Secondary Insurance Co: _____ Insurance Phone: _____Policy #:_____

Group #: _____ Employer: _____

Policy Holder's Name: _____ DOB: _____ SSN:_____

Statement of Financial Responsibility

I understand that payment for services, whether cosmetic or not, is solely the responsibility of the patient or their guarantor and as a courtesy Dr. Baldenhofer will bill my insurance. I hereby authorize Dr. Craig A. Baldenhofer to bill my insurance company or other third parties responsible for my medical charges. I also authorize Dr. Baldenhofer to release any medical information that may be requested by my insurance company to help with the process of my claims. I authorize and request that payment be made directly to Craig A. Baldenhofer M.D. Plastic & Reconstructive Surgery for all medical and surgical services. I understand that I am responsible for any balance not covered by my insurance company.

_____ _____ _____

Signature of patient/responsible party/legal guardian | Relationship to patient | Date

CRAIG BALDENHOFER, MD

craig@craigbaldenhofermd.com
www.craigbaldenhofermd.com

115 West 27th St, Ste 1001
New York, NY 10001
ph: 212-255-9800

199 Froehlich Farm Blvd
Woodbury, NY 11797

MEDICAL/SURGICAL HISTORY

CRAIG BALDENHOFER MD

Patient Name: _____ Today's Date: _____

What procedures are you interested in? _____

Are you in good health? **YES** **NO** If **NO**, provide reason: _____

Age: _____ Height: _____ Weight: _____

List all medications which you are currently or have taken in the last 6 months (prescription and non-prescription):

Medication(s) (ESPECIALLY ASPIRIN): **Amount:** **Frequency:**

_____

_____

_____

_____

Do you take herbal supplements (especially Gingko, Ginger, Garlic, St. John's Wort)?: _____

Do you take vitamins (especially C, E, Fish oils)?: _____

List all drug allergies: _____

Are you a smoker? **YES** **NO** If **YES**, how much: _____ How long? _____ Quit how long ago? _____

How much alcohol do you drink? _____ Caffeine? _____

Have you had the following?

☐YES ☐NO Chest Pain	☐YES ☐NO Anemia	☐YES ☐NO Problem w/ Scarring
☐YES ☐NO Heart Murmur	☐YES ☐NO Diabetes	☐YES ☐NO Emotional Problems
☐YES ☐NO Mitral Valve Prolapse	☐YES ☐NO Cancer	☐YES ☐NO Eye Disease
☐YES ☐NO Rheumatic Fever	☐YES ☐NO Breast Disease	☐YES ☐NO Eye Itching
☐YES ☐NO Palpitations	☐YES ☐NO Thyroid Cancer	☐YES ☐NO Eye Burning
☐YES ☐NO Shortness of Breath	☐YES ☐NO Hepatitis	☐YES ☐NO Dryness of Eyes
☐YES ☐NO Heart Disease	☐YES ☐NO Kidney Problems	☐YES ☐NO Bleeding Disorders
☐YES ☐NO High Blood Pressure	☐YES ☐NO Asthma	☐YES ☐NO Seizures

Is there any possibility that you may be pregnant at this time? **YES** **NO**

List all surgeries that you have had (Include Plastic Surgery):

Date: Surgery:

_____

_____

_____

Have you or anyone in your family ever had unusual reactions to anesthesia? **YES** **NO**

(Muscle weakness, jaundice, breathing problems or unexpected fevers)

Do you have (circle all that apply): **LOOSE OR CHIPPED TEETH / CAPS / DENTURES / CONTACT LENSES**

_____ _____

Patient Signature Date

CRAIG BALDENHOFER, MD

AMERICAN SOCIETY OF PLASTIC SURGEONS

American Board of Plastic Surgery ABMS MOC Certification Matters

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PHOTO RELEASE/CONSENT

CRAIG BALDENHOFER MD

I,_____agree that Craig A. Baldenhofer M.D. or designated representatives or the practice may take and use preoperative and postoperative photographs of my person for confidential clinical record purposes, and that such photographs shall remain the property of Craig A. Baldenhofer M.D.

_____ _____

Patient Signature Date

I fully and specifically grant my permission for the use of photographs, videotapes or case information for the following additional purposes as indicated by my initials below. As a result of this use I understand that these photographs, videotapes or case information may appear in other related, updated or reprinted formats at any concurrent or future occasion. I understand that such consent is strictly on a voluntary basis. I understand a copy of this consent may be supplied with the images to any third party wherein they may be published or presented. I understand that some photographs may, by their representation make me identifiable in appearance to others. I authorize Craig A. Baldenhofer M.D. to use my photographs, videotapes, and case information in the following educational and scientific settings that I have initialed:

_____ My surgeon's office patient education materials

_____ My surgeon's file of pre- and postoperative patient photographs available to prospective patients for viewing in the office

_____ Newspaper and magazine articles in which my surgeon participates

_____ Television programs in which my surgeon participates

_____ My surgeon's personal web site or web page

_____ Lectures and multimedia presentations given by my surgeon for the general public

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Printed Name of Patient or Personal Representative Relationship of Personal Representative to the Patient

_____

Signature of Practice Representative and Witness

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As a result of the Health Insurance Portability and Accountability Act (HIPAA), enforced by the US Department of Health and Human Services office of civil rights, we are not permitted to release patient information except as stated in the notice of privacy practices, or in accordance with your wishes as stated below.

This waiver authorizes Craig Baldenhofer M.D. to send/give my medical information as noted:

Leave a voicemail recording including my Personal Health Information on my cell phone.	Yes☐	No☐
Leave a voicemail recording including my Personal Health Information on my business phone.	Yes☐	No☐
Permit the individual stated below (Personal Representative) to receive prescriptions and/or request test results.	Yes☐	No☐
Speak to a family member of my choosing (Personal Representative) regarding my personal health information.	Yes☐	No☐

Name of personal Representative:_____

On this date, _____I received and reviewed the notice of privacy practices, which describes how my medical information may be used and disclosed and explained how I can get access to this information.

I have the opportunity to raise questions regarding this policy and all of my questions have been answered.

The authorizations made above will remain effective until such time as I notify Craig Baldenhofer, M.D. in writing, by certified mail, I have requested changes.

I hereby acknowledge that I have reviewed the Financial Agreement, the Outpatient Bill of Rights, and the Notice of Privacy Practices. I understand that copies are readily available upon my request.

_____ _____

Patient Signature Date

_____ _____

Social Security Number Date of Birth

_____

Patient Phone Number