

Charles Gruenwald, MD

AESTHETIC PLASTIC SURGERY

4309 Bluebonnet Blvd.
Baton Rouge, LA 70809
PH: 225-925-3140
FAX: 225-223-6010
www.drgruenwald.com

OUR OFFICE POLICY REQUIRES PAYMENT FOR OFFICE VISITS AT THE TIME OF SERVICE.

PATIENT INFORMATION

PLEASE PRINT CLEARLY

DATE _____

PATIENT'S FULL NAME _____ DATE OF BIRTH _____ AGE _____ SEX _____

PT. ADDRESS _____ CITY _____

STATE _____ ZIP _____ HOME PHONE # _____ WORK PHONE # _____

EMAIL ADDRESS: _____ CELL PHONE # _____

MARITAL STATUS: Single Separated Married Divorced

SOCIAL SECURITY NO. _____ DRIVER LICENSE NO. _____

EMPLOYED BY _____ ADDRESS _____

Who referred you to us? Physician _____ Friend/Relative _____ Yellow Pages Web Newspaper Magazine

NAME OF PERSON NOT LIVING WITH YOU TO BE NOTIFIED IN AN EMERGENCY _____

PHONE # _____

NAME OF SPOUSE (OR PARENT IF SINGLE) _____ SOCIAL SECURITY NO. _____

SPOUSE OR PARENT'S EMPLOYER _____ OCCUPATION _____

WHO IS RESPONSIBLE FOR PAYMENT? _____

RELATIONSHIP TO PATIENT: SELF SPOUSE PARENT GUARDIAN EMPLOYER OTHER

ADDRESS _____ CITY _____ STATE _____ ZIP _____

EMPLOYED BY _____ ADDRESS _____

CITY _____ STATE _____ ZIP _____ OCCUPATION _____

SOCIAL SECURITY NO. _____ DRIVER'S LICENSE NO. _____

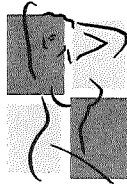
HOME PHONE # _____ EMPLOYER PHONE # _____

I understand that Charles Gruenwald, Jr., M.D. is not contracted with any insurance companies or managed care plans. Upon request, the practice will provide information so I may file my insurance claim myself, if I desire to do so. Claims filed with my insurance will be paid as "out of network" since Dr. Gruenwald is not a contracted provider. I further understand that I am financially responsible for all services provided by Dr. Gruenwald or his staff, and that payment is due in advance of surgery.

SIGNATURE _____
Patient, Parent, or Legal Guardian

SIGNATURE _____
Other Account Guarantor

DATE _____



Charles Gruenwald, MD

AESTHETIC PLASTIC SURGERY

4309 Bluebonnet Blvd.

Baton Rouge, LA 70809

PH: 225-925-3140

FAX: 225-223-6010

www.drgruenwald.com

Confidential Record

Information contained here will not be released except when you have authorized us to do so. Please answer all questions to the best of your knowledge. The information provided by you will be used by your doctor in decisions regarding your care.

Name: _____
Last First Middle

Age _____ Ht. _____ Wt. _____ Sex _____ Marital Status: S M W D or Separated

Date of Last Physical Examination _____ Physician's Name _____

Family or Referring Physician _____ Address & Phone No. _____

DO YOU HAVE OR HAVE YOU HAD: (CIRCLE)

Stroke	YES	NO	Bladder Infection	YES	NO
Cancer	YES	NO	Asthma	YES	NO
Tuberculosis	YES	NO	Heart Attack	YES	NO
Leukemia	YES	NO	Stomach Ulcers	YES	NO
Bronchitis	YES	NO	Kidney Disease	YES	NO
Epilepsy	YES	NO	Tonsillitis	YES	NO
Pneumonia	YES	NO	Keloids / Thick Scars	YES	NO
Diabetes	YES	NO	Rheumatic Heart	YES	NO
Arthritis	YES	NO	Bleeding Tendency	YES	NO
Depression	YES	NO	High Blood Pressure	YES	NO
Hepatitis / Jaundice	YES	NO	Congenital Heart Disease	YES	NO
Migraine	YES	NO	Nervous Breakdown	YES	NO
Hay Fever	YES	NO	Dizziness / Fainting	YES	NO
Colitis	YES	NO	AIDS	YES	NO
Goiter	YES	NO	Sickle Cell Disease	YES	NO
Mitral Valve Prolapse	YES	NO	Latex Allergies	YES	NO
Sleep Apnea with or without CPAP machine	YES	NO	Deep Venous Thrombosis	YES	NO

What procedure are you interested in? _____

Do you wear dentures? YES NO

Do you smoke? YES NO How much? _____ How many years? _____

Do you drink alcohol or beer regularly? YES NO How much? _____

Date of Last Chest X-ray _____ Date of Last EKG _____

ARE YOU PRESENTLY TAKING ANY OF THE FOLLOWING MEDICATIONS? (CIRCLE)

Aspirin, Bufferin, Anacin	YES	NO	Medicine for Arthritis	YES	NO
Blood pressure pills	YES	NO	Tranquilizers	YES	NO
Cortisone	YES	NO	Weight reducing pills	YES	NO
Digitalis	YES	NO	Blood thinning pills	YES	NO
Hormones	YES	NO	Dilantin	YES	NO
Insulin or diabetic pills	YES	NO	Shots	YES	NO
Iron or poor blood meds	YES	NO	Water pills	YES	NO
Laxatives	YES	NO	Antibiotics	YES	NO
Sleeping pills	YES	NO	Barbiturates	YES	NO
Thyroid medicine	YES	NO	Birth control pills	YES	NO
Headache pills	YES	NO	Phenobarbital	YES	NO
Have you ever taken or are you presently taking diet pills?	YES	NO	When? _____		
Other drugs not listed: Name _____			dosage _____		

Write in the names and dates of any operations which you have had: _____

Name any drugs or foods to which you are allergic: _____

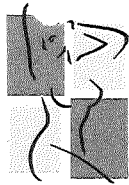
Serious injuries or accidents: _____

Do you have eye problems? ("dry eye syndrome", glaucoma, detached retina, allergic reactions, etc.)	YES	NO
Do you wear glasses or contact lenses?	YES	NO
Have you ever had a blood transfusion?	YES	NO
Do you frequently have bleeding gums?	YES	NO
Have you ever bled excessively from a tooth extraction?	YES	NO
Do you bleed excessively from a laceration?	YES	NO
Do you have nose bleeds?	YES	NO
How often? _____		
Do you take aspirin regularly?	YES	NO
How often? _____		
(Yes, stop taking aspirin until two weeks after your surgery)		

WOMEN ONLY

Are you still having regular monthly menstrual periods?	YES	NO
Are you now on or have you ever taken the birth control pill? When? _____	YES	NO
Have you ever had bleeding between your periods? When? _____	YES	NO
Do you have very heavy bleeding with your periods? When? _____	YES	NO
Date of last Pap Smear Test _____		
Any complications of pregnancy? _____		
Date of last menstrual period _____ Could you be pregnant now? _____		
Do you have any family history of breast cancer? _____		
Date of last mammogram _____		

NOTE: We recommend regular breast and pelvic exams by your regular physician for all adults.



Charles Gruenwald, MD

AESTHETIC PLASTIC SURGERY

4309 Bluebonnet Blvd.
Baton Rouge, LA 70809
PH: 225-925-3140
FAX: 225-223-6010
www.drgruenwald.com

Authorization for Use or Disclosure of Protected Health Information

I authorize my physician and/or administrative and clinical staff of Dr. Gruenwald, to disclose general medical information and other protected health information to the following persons and/or entities listed below. If no one is listed below, protected health care information will not be disclosed except in those situations described in the Notice of Privacy Practices for Dr. Gruenwald.

Name and relationship of the person you wish to allow access – for example, your spouse, child, sibling, neighbor, caretaker, clergy, or close friend:

Name of Person or Entity	Relationship

This authorization to use and disclose this protected health information is being submitted by my request and shall be in force and effect until revoked in writing by me.

I understand that information used or disclosed pursuant to this authorization may be disclosed by Associates in Plastic Surgery and may no longer be protected by federal or state law.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Privacy Officer. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information to obtain payment from my health insurance company.

Signature of Patient or Personal Representative

Print Name of Patient or Personal Representative

Description of Personal Representative's Authority

Date

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices.

Signed: _____ Date: _____

Print:
Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship and describe authority to act:

- parent or guardian of minor patient
- guardian or conservator of an incompetent patient
- beneficiary or personal representative of deceased patient

Name of Patient: _____

<p><i>For Office Use Only:</i></p> <p>Signed form received by: _____</p> <p>Acknowledgement refused:</p> <p>Good Faith Efforts to obtain Acknowledgement:</p> <p>_____</p> <p>_____</p> <p>Reasons acknowledgement was not obtained:</p> <p>_____</p>
