MOKHTAR ASAADI, M.D., F.A.C.S.
ASAADI PLASTIC SURGERY

101 OLD SHORT HILLS ROAD | SUITE 504 | WEST ORANGE, NJ | 07052
620 PARK AVENUE | NEW YORK, NY | 10065

(Please PRINT & Complete all items below)

PATIENT INFORMATION: DATE:

Patient's Name ______________________ Age ________ Date of Birth ______________

Email Address ______________________ Social Security Number ______________

Home Phone ______________________ Mobile Phone ______________

Home Address ______________________ City ____________ State ______ Zip ________

Current Marital Status (check the appropriate box) Married ☐ Single ☐ Widow(er) ☐ Divorced ☐ Separated ☐

Patient's Occupation ______________________ Employer ______________

Business Address ______________________ Business Phone ______________ Ext. ______

Spouse's Occupation ______________________ Employer ______________

Business Address ______________________ Business Phone ______________ Ext. ______

Family Internist/Pediatrician ______________________ Address ______________

Patient Referred By ______________________

Address ______________________ Phone ______________

Has this office previously treated any member of your family? ________ Whom ______________

FINANCIAL RESPONSIBILITY

My bill will be paid by: ☐Patient ☐Spouse ☐Father ☐Mother ☐Workmen's Comp. ☐No Fault ☐Other (specify)

____

Name of Spouse/ Parent ______________________ Spouse/Parent's Occupation ______________

Spouse/Parent's Employer ______________________ Employer's Address ______________

Business Phone ______________ Ext. ______

If other, name and address ______________________

HEALTH INSURANCE

ID # ______________________ Group # ______________

Subscriber's name ______________________

WHERE ATTORNEY IS INVOLVED

Attorney's Name ______________________ Phone # ______________

Address ______________________

DESCRIBE WHAT BRINGS YOU HERE

____

____

____

IF INJURY, DATE________________ AT WORK? (Describe)____

MOTOR VEHICLE? __________ Driver ☐ Passenger ☐ Pedestrian ☐

(Describe) ____

____

Were you treated by another doctor or at a hospital for this injury? (Describe) ____________________________

____

PAST MEDICAL HISTORY

Height__________Present Weight_________

Any significant weight loss in the past year? Yes ☐ No ☐

If yes, how much ______________

DATE	SURGERY/ILLNESS	DOCTOR & HOSPITAL

SERIOUS INJURIES

DATE	SURGERY/ILLNESS	DOCTOR & HOSPITAL

ALLERGIES: (please list all including drugs, food, seasonal)_______________________________________

____

MEDICATIONS/DRUGS: (please list ALL you are now taking including birth control pills, diuretics (water pills), blood pressure or heart medications, tranquilizers, hormones, steroid medications, cortisone, blood thinners, aspirin, bufferin, etc.)_________________________

____

____

HAVE YOU EVER BEEN PREGNANT? YES ☐ NO ☐ HOW MANY TIMES? ____________________________

ARE YOU PREGNANT NOW? YES ☐ NO ☐ HOW MANY CHILDREN DO YOU HAVE ? ____________________

ARE YOU PLANNING MORE CHILDREN? YES ☐ NO ☐

DO YOU SMOKE? YES ☐ NO ☐ (describe) _______________________ HOW MUCH PER DAY____________________

ALCOHOL CONSUMPTION __________________________ HOW MUCH PER DAY/WEEK ____________________

CONSUMPTION OF COFFEE/TEA/CAFFEINATED BEVERAGES ____________________________________

HOW MUCH PER DAY/WEEK____

DO YOU HAVE OR HAVE YOU HAD ANY SIGNIFICANT EMOTIONAL PROBLEMS? YES☐ NO☐ (describe)

____

____

____

HAVE YOU EVER HAD PSYCHIATRIC / PSYCHOLOGIC CARE? YES ☐ NO☐ (describe)

____

____

____

HAVE YOU EVER BEEN ADVISED TO SEE A PSYCHIATRIST? YES ☐ NO☐ BY WHOM? ______________________________

DO YOU TAKE ANY MIND ALTERING DRUGS? YES ☐ NO☐ (describe) ______________________________

HAVE YOU HAD ANY ILLNESSES OR DISORDERS OF THE FOLLOWING? (Circle if YES)

BRAIN (including strokes Epilepsy)	FACE (paralysis)	LUNGS (including Asthma)	INTESTINES/BOWELS	BLOOD
BONES OR JOINTS	ARMS OR LEGS	NOSE, SINUS, THROAT	EYES (including tearing/ dryness)	LIVER
HEART OR BLOOD VESSELS	REPRODUCTIVE SYSTEM	BREASTS	EARS (including deafness)	STOMACH
URINARY SYSTEM	NERVOUS SYSTEM	ENDOCRINE OR DIABETES	SKIN	BLOOD PRESSURE

IF CIRCLED, PLEASE EXPLAIN:

____

____

____

____

ASSIGNMENT OF INSURANCE BENEFITS (Please Sign)

I, THE UNDERSIGNED, HAVE INSURANCE COVERAGE WITH ______________________________ AND ASSIGN
(Insurance Company)

DIRECTLY TO MOKHTAR ASAADI, M.D., F.A.C.S., P.A. ALL SURGICAL AND / OR MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID IN INSURANCE. I HEREBY AUTHORIZE THE DOCTOR TO RELEASE INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS.

DATE ____________ SIGNED ______________________________

(TO BE USED ONLY IN THE EVENT PAYMENT IS NOT MADE PRIOR TO SURGERY, I.E. SECONDARY OR EMERGENCY SURGERIES).

SIGNATURE OF PATIENT/PARENT/GUARDIAN ______________________________

RELATIONSHIP TO PATIENT ______________________________