

Ernest M. Sussman, MD
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PATIENT INFORMATION: PLEASE PRINT

DATE: _____

Name: _____ Date of Birth: _____ Age: _____ Marital Status: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Social Security#: _____

Employer: _____ Work Phone: _____

Emergency Contact: _____ Relation: _____ Phone: _____

MEDICATIONS: _____

ALLERGIES: _____ BLEEDING DISORDERS: _____

OPERATIONS: _____

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT:

I hereby authorize medical treatments for myself and fully acknowledge that all office visits including procedures are on a no-insurance (self-pay) basis. Payment in full is expected at the time of service, unless other arrangements have been made prior. **I further understand that Dr. Sussman does not participate in Medicare, Medicaid, or other commercial insurance companies so am responsible for all fees incurred.**

Please initial at each 'X' below and sign:

X _____ I understand that all deposits made to hold my appointment times are non-refundable, unless the office is given notice at least 5 business days prior. In the event of default on any payment due to **Dr. Sussman**, I agree to pay the costs of collection and/or attorney fees.

X _____ I hereby authorize the office of **Dr. Sussman** to release all pertinent medical records necessary to facilitate insurance billing or medical care. I also authorize the creditor or higher agent to make any employment, or insurance verification and release all information to process claims.

Signature: _____ Date: _____

PAST MEDICAL, FAMILY, SOCIAL HISTORY (CHECK AND *CIRCLE WHICH APPLY*)

	YOU	FAMILY
High blood pressure, heart attack, heart failure, irregular heart rhythm	_____	_____
Breathing problems (asthma, COPD, emphysema, chronic bronchitis)	_____	████████
Blood thinners (aspirin, coumadin, Eliquis, ibuprofen, Plavix, Xarelto)	_____	████████
Prosthetic or implant surgery (heart valves, pacemaker, orthopedic, penile)	_____	████████
History of diabetes, tuberculosis or hepatitis	_____	_____
Cancer of prostate, bladder, kidney, or other _____	_____	_____
Risk for HIV (homosexual, blood transfusions, hemophilia)	_____	████████
Do you or have you ever smoked? If you quit, when? _____	_____	████████
Alcohol or drug _____ use (social, moderate, heavy)	_____	_____