Samuel J. Mucci, M.D., P.C.

ADMINISTRATIVE INFORMATION

Soc. Sec. #__________________________ DOB: ______________ Gender: ______ Marital Status:_______

Last Name_________________________________ MI____ First Name ____________________________

Address____ City _________________ State ______ Zip ________

Parents *if minor*: Father____________ Mother___________

Phone # _____________________________ Phone work/cell______________________

Fax # _________________________________ E-mail __________________________________

Emergency contact/ Relationship____ Phone _________________

Employer __________________________________ Position held/Occupation_____________________________

Family Physician____________________________ Physician Phone__________________________________

Referred by_________________________________ ***If doctor***, list phone_______________________________

Is this visit due to an auto accident? _______ Claim #_____________ Contact person_____________________

Primary Insurance _________________________________ ID # ____

Group #________________________Subscriber's Full Name ____

Subscriber's Birthdate____________________________

If subscriber's address is different than yours, please list____

____

Secondary Insurance_________________________________ID #____

Pharmacy_______________________________ Pharmacy Phone____

Pharmacy address____

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PATIENT MEDICAL INFORMATION

Patient Name____ ***Date***_________________

Medication, dosage and frequency:

____

____

____

Allergies____ ***Latex allergy*** yes / no

Influenza vaccine (Flu Shot) ______yes ______no Pneumonia vaccine ____yes_____no

Past Medical History: (Circle which apply)

Anemia	Blood clots	COPD or emphysema	Cancer/type____________
Asthma	Coronary artery disease	Peripheral vascular disease	Ulcers
Hepatitis	Hypertension	Congestive heart failure	Heart murmur
Arthritis	Diabetes	Irregular heart beat	Pacemaker/ICD
Hepatitis	Reflux	Seizures	Strokes
TB	Dialysis Other____		

***Surgical History*:**____

____

***Social History*:** Current smoker: Yes/No________ Pack per day______ Former smoker: Yes/No ______

Pack per day upon quitting: _______Year quit: _______ Alcohol: Yes/No _______Per Day________

Family Medical History: ____

____

Symptoms: (Circle which apply)

Chest pain	Nausea/Vomiting	Altered Bowel Habits
Shortness of Breath	Diarrhea/Constipation	Altered Bladder Habits
Cough	Dizziness/Light headedness	Dyspepsia/Dysphagia
Sore Throat	Visual Disturbances	Anorexia/Weight Loss
Fever/Chills	Hearing Problems	Weakness in Extremities

Have you ever had complications with anesthesia ?____

Have you ever had a problem with bleeding / bruising? ____

Height_____________ Weight_____________ BMI(weight loss patients)_____________________

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PATIENT INFORMATION

Patient Name ___________________________________ ***Date*** _________________________

Please circle all the procedures in which you are interested:

Breast Augmentation	Nasal Recontouring	Eyelid Surgery	Skin Care Products
Breast Reduction	Lower Body Lift	Face Lift	Laser Resurfacing
Breast Lift	Arm Reduction	Neck Lift	Botox
Breast Reconstruction	Brow Lift	Ear Surgery	Radiesse
Liposuction	Panniculectomy	Thigh Reduction	Restylane/Juvederm
Tummy Tuck			

Other____

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I understand that the information provided herein is to the best of my knowledge correct and complete. I hereby authorize the release of any medical information necessary for the purpose of processing insurance claims on my behalf and request payment to be made directly to Samuel J. Mucci, M.D., P.C. I also authorize Dr. Mucci to release information to any hospital or physician that I may be referred to by this office. I authorize Dr. Mucci to take photographs and to utilize them in scientific or educational seminars at his discretion.

Signature:____Date:_____________________

Witness:____Date:_____________________