David E Lipson, M.D. F.A.C.S.

Name of Patient _____ Martial Status: S M D W
(First) *(Middle)* *(Last)*

Female ☐ Male ☐ **Date of Birth** ___/___/___ Age _____ **Soc. Sec. No.** _____

Street Address _____ **Home Telephone (** **)** _____

City _____ **State** _____ **Zip Code** _____

Occupation _____ Employer _____

Business Address _____ Bus. Telephone (___) _____

Spouse's Name _____ Date of Birth ___/___/___ Soc. Sec. No. _____

Spouse's Occupation/Employer/Address _____

_____ Business Telephone (___) _____

If patient is a minor (under 18): I give permission for _____ to receive treatment from Dr. Lipson.

Signature: _____ Parent or Guardian.

Print Signature: _____ Parent or Guardian.

Medicare Insurance Information: ID# _____ Effective Date _____

Secondary Insurance. if applicable: _____ ID# _____

Referred By: ☐ Relative ☐ Friend ☐ Doctor (Name & Address)

☐ Hospital ☐ Yellow Pages ☐ (Internet, drive-by) or other (Please specify) _____

MEDICAL HISTORY

Primary Doctor: _____ Eye Doctor: _____

Name of Gynecologist, if applicable _____ Are you pregnant? _____

If you have had any of the following, please indicate with a check mark:

____ Any heart problems	____ Reaction to anesthetics	____ Excessive bleeding
____ High blood pressure	____ Allergy to medicines	____ Nervous problems
____ Low blood pressure	*Please List:* _____	____ Diabetes
____ Circulatory problems	____ Radiation treatments	____ Hepatitis
____ Problems w/Anesthesia	____ Anemia	____ Asthma

Do you smoke? _____ If yes, how much? _____

Are you taking aspirin on a regular basis? _____ If yes, how much? _____

Please list regular medicine & dosage _____

What are you counsulting the doctor for today? _____

RECORDS RELEASE

I authorize the release of any information, including the diagnosis and records of any treatment or examination rendered to me or my child, to third party payors and/or other health practitioners. I understand that I am responsible for fees generated in the care of myself/patient _____

I also consent to the taking of medical photographs, as well as their use for ethical, medical and educational purposes

_____ Date ___/___/___

Signature of Patient (or parent, if patient is a minor)