

**Eric S. Rothenberg M.D. F.A.C.S.,**  
**Aesthetic and Reconstructive Plastic Surgery**  
**Surgery of the Hand**



**Patient's Name:** \_\_\_\_\_ **SS#:** \_\_\_\_\_

**DOB:** \_\_\_\_\_ **AGE:** \_\_\_\_\_ **Spouse's Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City/State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Home#:** \_\_\_\_\_ **Cell#:** \_\_\_\_\_ **Work#:** \_\_\_\_\_

**Patient's Employer:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_

**Position:** \_\_\_\_\_ **Full Time:** \_\_\_ **Part Time:** \_\_\_ **Retired:** \_\_\_ **Other:** \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ **Phone#:** \_\_\_\_\_

**Insurance information:**

**Primary Insurance:** \_\_\_\_\_

**Primary Holders Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_ **SS#** \_\_\_\_\_

**Policy ID#:** \_\_\_\_\_ **Group#:** \_\_\_\_\_

**Ins.Address:** \_\_\_\_\_ **City/State:** \_\_\_\_\_

**Phone#:** \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_

**Primary Holders Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_ **SS#** \_\_\_\_\_

**Policy ID#:** \_\_\_\_\_ **Group#:** \_\_\_\_\_

**Insurance Authorization and Assignment**

I hereby authorize Dr. Eric S. Rothenberg, M.D. to furnish information to insure carriers concerning my illness and treatments. I hereby assign Dr. Eric Rothenberg all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Referring Physician:** \_\_\_\_\_

**Purpose of Visit or History of Injury:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Previous Surgery:**

| <b>Operation</b> | <b>Year</b> | <b>Hospital</b> | <b>Surgeon</b> |
|------------------|-------------|-----------------|----------------|
| _____            | _____       | _____           | _____          |
| _____            | _____       | _____           | _____          |
| _____            | _____       | _____           | _____          |

**Have you ever been treated for any of the following:**

**High Blood Pressure**      No \_\_\_\_\_      Yes \_\_\_\_\_

**Shortness of Breath**      No \_\_\_\_\_      Yes \_\_\_\_\_

**Diabetes**      No \_\_\_\_\_      Yes \_\_\_\_\_

**Blood Disorders**      No \_\_\_\_\_      Yes \_\_\_\_\_

**Lung Disease**      No \_\_\_\_\_      Yes \_\_\_\_\_

**Kidney Disease**      No \_\_\_\_\_      Yes \_\_\_\_\_

**Stroke**      No \_\_\_\_\_      Yes \_\_\_\_\_

**Poor Scarring**      No \_\_\_\_\_      Yes \_\_\_\_\_

**Serious Medical Disorders:**

\_\_\_\_\_  
\_\_\_\_\_

**Allergies to Drugs:**

\_\_\_\_\_  
\_\_\_\_\_

**List all medications currently being taken by the Patient:**

---

---

---

**Have you ever taken Steroid Medication?:** No: \_\_\_\_\_ Yes: \_\_\_\_\_ **Date last taken?:** \_\_\_\_\_

**Do you smoke?:** No: \_\_\_\_\_ Yes: \_\_\_\_\_ **How many packs per day?:** \_\_\_\_\_

**Do you drink alcohol?:**No: \_\_\_\_\_ Yes: \_\_\_\_\_

**How Often?:** Rarely: \_\_\_\_\_ Occasionally: \_\_\_\_\_ Often: \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_