MANHATTAN PLASTIC SURGERY, PLLC
ANTHONY N. LABRUNA, MD

Welcome To Our Office!

1. Your appointment time is reserved for you. If you must reschedule your appointment, please try to do so in a timely fashion so that another patient may be accommodated and you can be rescheduled promptly. We kindly ask for at least a 24 cancellation notice.

2. We will call or email you 1-2 days before your appointment to confirm. Please provide us with your best contact number(s) and/or email on the patient information sheet. Telephone calls from patients (and their parents if under 18) are welcome during office hours. We will make every effort to return calls promptly if you call outside of normal office hours.

3. To make your visit more efficient we kindly ask you to fill out these registration forms ahead of time and bring them with you completed on the day of your initial visit.

Please do not hesitate to ask any questions pertaining to your office procedure or other concerns you may have. We value communication and an open, trusting relationship with our patients.

MANHATTAN PLASTIC SURGERY, PLLC **ANTHONY N. LABRUNA, MD**

Patient Information as of _____ (enter today's date)

Patient's Name _____
First Middle Last

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Other Phone _____

E-mail _____

Birth Place: _____

Age _____ Birthdate _____ SS# _____ Gender ❒ Female ❒ Male

Marital Status ❒ Single ❒ Married to: _____ ❒ Other: _____

Patient's Employer _____ Occupation _____

Work Phone _____ Ext: _____ Is it okay to call you at work? ❒ Yes ❒ No

Address _____
Street & Suite # City State Zip

How did you hear about Dr. LaBruna, M.D.? (Mark all that apply)

❒ Friend/Relative: _____ ❒ Doctor: _____ ❒ Other: _____

❒ Magazine ❒Salon ❒Staff ❒ Seminar

Emergency Contact _____ Relationship to Patient _____

Home Phone _____ Work Phone _____ Other Phone _____

Primary Health Insurance Company _____

Policy # _____ Group # _____ Ins. Phone _____

Insured: Name _____ DOB: _____

***Pharmacy Name** _____ **Pharmacy Address** _____

***Pharmacy Telephone #** _____

May we text or email you when your scripts are ready? ❒Yes ❒No

I understand that office visit charges are payable on the day service is rendered. I authorize Manhattan Plastic Surgery, PLLC to bill my insurance company for medically necessary services. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Dr. LaBruna and myself.

Signature _____ **Date** _____

Anthony LaBruna, MD
45 East 85th St
New York, NY 10028

MANHATTAN PLASTIC SURGERY, PLLC **ANTHONY N. LABRUNA, M.D.**

Health Information as of _____ (enter today's date)

(Please Print Legibly & Fill In or Correct All Fields)

Name: _____ Reason for Visit: _____

DOB: _____ Height: _____ Feet _____ Inches Weight: _____ Lbs.

Current Physician(s): _____

List all Surgeries (Hospitalization and the Date of Occurrence):

List any Serious Illnesses and/or Accidents:

Do you have or have you had any of the following: (circle for each, give date occurred if Yes)

Aids / HIV	No	Yes	Epilepsy / Seizures	No	Yes	Kidney Problems	No	Yes
Arthritis	No	Yes	Facial Pain	No	Yes	Pneumonia	No	Yes
Asthma	No	Yes	Fever Blisters	No	Yes	Sinus Problems / Infections	No	Yes
Bronchitis	No	Yes	Goiter / Thyroid	No	Yes	Stroke	No	Yes
Cancer	No	Yes	Hay Fever / Allergies	No	Yes	Tonsillitis	No	Yes
Depression	No	Yes	Headaches / Migraine	No	Yes	Tuberculosis	No	Yes
Diabetics	No	Yes	Heart Trouble	No	Yes	Ulcers	No	Yes
Dizziness / Vertigo	No	Yes	Hepatitis	No	Yes	Weight Gain/Loss	No	Yes
Ear Infection	No	Yes	High Blood Pressure	No	Yes			

Do you smoke? No Yes If yes, how much? _____ Pack(s)/day How long? _____ Years

Do you drink alcohol? No Yes If yes, how much? _____ How often? _____

Do you use recreational drugs? No Yes If yes, describe: _____

List the name of all medications you are presently taking or have taken within the last month. Please include the name of the drug, dosage and frequency.

List ALL drug and/or latex allergies.

The above information is accurate and complete to the best of my knowledge.

Signature _____ **Date** _____

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New York, NY 10028

Financial Policy

Welcome to Mahattan Plastic Surgery. The following is a statement of our financial policy. We hope this give you a better undrestanding of how our billing works. Insurance plans will not cover cosmetic procedures. Payment is due at the time of service.

Payment
Cash, Check, Visa, Mastercard, Discover and American Express cards are recognized forms of payment. We hope this information is helpful. Complete payment for all services is required at the time of service or prior to your surgical procedure. If you have any questions please contact Donna Hoey at 646-588-4470.

Insurance Plans
Dr. LaBruna does not participate in any insurance plans. We can submit the claim directly to your carrier or a claim can be mailed directly to you.

Signature _____ Date _____

Assignment of benefits and authorization to release medical information

I authorize and direct Manhattan Plastic Surgery, PLLC and its physicians, having treated me, to release to governmental agencies, insurance carriers, or others who are financially liable for my medical care, all information needed to substantiate payment for such medical care and permit representatives thereof to examine and make copies of all records relating to such care and treatment. I hereby assign, transfer, and set over to Manhattan Plastic Surgery sufficient monies and or benefits to which I may be entitled from governmental agencies, insurance carriers, or others who are financially liable for my medical care to cover the costs of the care and treatment rendered to myself or my dependents. I request that payment of authorized benefits be made on my behalf, and I understand I am responsible for charges not covered by policy or plan.

Signature _____ Date _____

HIPPA Privacy Policy

I have had the opportunity to read and review the privacy practices in this office, which are displayed at the front desk. I also understand copies are available upon request.

Signature _____ Date _____

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