

BARRY S. CITRON, M.D., F.A.C.S.
PLASTIC AND RECONSTRUCTIVE SURGERY / COSMETIC AND LASER SURGERY
315 EAST NORTHFIELD ROAD, SUITE 2A, LIVINGSTON NJ 07039
TEL: 973 535-5222 FAX: 973 535-1450
www.drcitron.com

DATE _____ FAMILY OR REFERRING DR. _____	
NAME _____	AGE _____ BIRTH DATE ____/____/____
ADDRESS _____	
CITY _____	STATE _____ ZIP _____ E-mail _____
PATIENT S.S.# _____	PHONE _____ MOBILE _____
SEX M <input type="checkbox"/> F <input type="checkbox"/>	MARITAL STATUS S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D <input type="checkbox"/>
PATIENT EMPLOYER & ADDRESS _____	
EMPLOYER PHONE _____	OCCUPATION _____
REFERRED BY WHOM: _____	
SPOUSE OR NEAREST RELATIVE _____	PHONE _____
ADDRESS _____	RELATIONSHIP _____
REASON FOR VISIT _____	

RESPONSIBLE PERSON NAME _____	S.S. # _____
ADDRESS _____	
PHONE (H) _____	(W) _____ RELATIONSHIP _____
EMPLOYER & ADDRESS _____	

INSURANCE INFORMATION

PRIMARY CARRIER _____	SUBSCRIBER _____	DATE OF BIRTH _____
ADDRESS _____		
POLICY # _____	GROUP # _____	PLAN _____
SECONDARY CARRIER _____	SUBSCRIBER _____	DATE OF BIRTH _____
ADDRESS _____		
POLICY # _____	GROUP # _____	PLAN _____

I authorize the release of my healthcare information for treatment, payment or healthcare operational purposes. Although this office will assist in filing claims, I understand that I am financially responsible for all fees incurred. All surgery and cosmetic services must be cancelled 24 hours in advance to avoid additional charges.

Signature _____ Date _____

MEDICAL HISTORY

NAME _____ WEIGHT _____ HEIGHT _____

SURGERY (OPERATIONS):

TYPE	DATE	COMPLICATIONS
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

ADMISSIONS TO HOSPITAL:

REASON	DATE	COMPLICATIONS
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

MEDICATIONS (ANY DRUG, MEDICATION, HERBAL MEDICATION) YOU TAKE NOW:

TYPE	DOSAGE	TAKEN HOW OFTEN?
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

CONSUMPTION OF THE FOLLOWING:

ASPIRIN _____	AMOUNT DAILY _____	AMOUNT WEEKLY _____
ALCOHOL _____	AMOUNT DAILY _____	AMOUNT WEEKLY _____
TOBACCO _____	AMOUNT DAILY _____	AMOUNT WEEKLY _____

BLEEDING PROBLEMS (WITH CUTS, TOOTH EXTRACTIONS, PREGNANCY, SURGERY?)

EXPLAIN:

DIFFICULTIES WITH LOCAL OR GENERAL ANESTHESIA:

EXPLAIN:

HAVE YOU EVER TAKEN ACCUTANE? YES NO
WHEN?

HAVE YOU EVER TAKEN PHEN/FEN? YES NO
WHEN?

MEDICAL PROBLEMS OR CONDITIONS UNDER TREATMENT BY A PHYSICIAN:

EXPLAIN:

ALLERGIES, ILLNESSES AND MEDICAL PROBLEMS

NAME _____ DATE _____

DO YOU HAVE ALLERGIES TO THE FOLLOWING ?

	YES	NO	DESCRIBE REACTION
PENICILLIN?	<input type="checkbox"/>	<input type="checkbox"/>	_____
ERYTHROMYCIN?	<input type="checkbox"/>	<input type="checkbox"/>	_____
SULFA?	<input type="checkbox"/>	<input type="checkbox"/>	_____
IODINE?	<input type="checkbox"/>	<input type="checkbox"/>	_____
CONTACT ALLERGY?	<input type="checkbox"/>	<input type="checkbox"/>	_____
TAPE?	<input type="checkbox"/>	<input type="checkbox"/>	_____
OTHER?	<input type="checkbox"/>	<input type="checkbox"/>	_____

EXPLAIN ALLERGIC EFFECTS: _____
 DATE OF LAST TETANUS SHOT: _____

ILLNESSES & MEDICAL PROBLEMS:

YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	BRONCHITIS
<input type="checkbox"/>	<input type="checkbox"/>	HEART ATTACK	<input type="checkbox"/>	<input type="checkbox"/>	EMPHYSEMA
<input type="checkbox"/>	<input type="checkbox"/>	HEART MURMUR	<input type="checkbox"/>	<input type="checkbox"/>	ASTHMA
<input type="checkbox"/>	<input type="checkbox"/>	RHEUMATIC FEVER	<input type="checkbox"/>	<input type="checkbox"/>	PNEUMONIA
<input type="checkbox"/>	<input type="checkbox"/>	OTHER HEART PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	TUBERCULOSIS
<input type="checkbox"/>	<input type="checkbox"/>	PRIOR STEROID THERAPY	<input type="checkbox"/>	<input type="checkbox"/>	LUNG PROBLEMS
<input type="checkbox"/>	<input type="checkbox"/>	DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	ANESTHESIA PROBLEMS
<input type="checkbox"/>	<input type="checkbox"/>	DIZZY SPELLS	<input type="checkbox"/>	<input type="checkbox"/>	STOMACH ULCER
<input type="checkbox"/>	<input type="checkbox"/>	GLAUCOMA	<input type="checkbox"/>	<input type="checkbox"/>	COLITIS
<input type="checkbox"/>	<input type="checkbox"/>	OTHER EYE PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	DIVERTICULOSIS
<input type="checkbox"/>	<input type="checkbox"/>	EAR TROUBLE	<input type="checkbox"/>	<input type="checkbox"/>	BOWEL PROBLEMS
<input type="checkbox"/>	<input type="checkbox"/>	SINUS TROUBLE	<input type="checkbox"/>	<input type="checkbox"/>	HEPATITIS
<input type="checkbox"/>	<input type="checkbox"/>	DEAF, HEARING-IMPAIRED	<input type="checkbox"/>	<input type="checkbox"/>	MONONUCLEOSIS
<input type="checkbox"/>	<input type="checkbox"/>	NOSE BLEEDS	<input type="checkbox"/>	<input type="checkbox"/>	GALLBLADDER TROUBLE
<input type="checkbox"/>	<input type="checkbox"/>	NOSE OBSTRUCTION	<input type="checkbox"/>	<input type="checkbox"/>	STROKE
<input type="checkbox"/>	<input type="checkbox"/>	NASAL FRACTURE	<input type="checkbox"/>	<input type="checkbox"/>	CONVULSIONS, SEIZURES
<input type="checkbox"/>	<input type="checkbox"/>	SWELLING IN NECK	<input type="checkbox"/>	<input type="checkbox"/>	SCARLET FEVER
<input type="checkbox"/>	<input type="checkbox"/>	HEALING PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	KIDNEY / BLADDER PROBLEMS
<input type="checkbox"/>	<input type="checkbox"/>	HERNIAS	<input type="checkbox"/>	<input type="checkbox"/>	VARICOSE VEINS
<input type="checkbox"/>	<input type="checkbox"/>	LOW BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	SPIDER VEINS
<input type="checkbox"/>	<input type="checkbox"/>	ARTHRITIS	<input type="checkbox"/>	<input type="checkbox"/>	PARALYSIS
<input type="checkbox"/>	<input type="checkbox"/>	LUPUS, AUTOIMMUNE DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	ANKLE SWELLING
<input type="checkbox"/>	<input type="checkbox"/>	BLEEDING PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	MENTAL / NEUROLOGICAL CONDITION
<input type="checkbox"/>	<input type="checkbox"/>	BRUISE EASILY			
<input type="checkbox"/>	<input type="checkbox"/>	SKIN CANCER (BASAL CELL CARCINOMA, SQUAMOUS CELL CARCINOMA OR MELANOMA)			

PRECANCEROUS LESIONS (ACTINIC KERATOSIS, ATYPICAL DYSPLASTIC NEVUS)

CANCER year/type

WOMEN:

<input type="checkbox"/>	<input type="checkbox"/>	TENDER BREASTS	LAST MAMMOGRAM YEAR _____
<input type="checkbox"/>	<input type="checkbox"/>	FIBROCYSTIC BREASTS	<input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL
<input type="checkbox"/>	<input type="checkbox"/>	MENSTRUAL PROBLEM	LAST MENSTRUAL PERIOD _____
<input type="checkbox"/>	<input type="checkbox"/>	WERE YOUR CHILDREN BREAST FED?	NUMBER OF CHILDREN _____
<input type="checkbox"/>	<input type="checkbox"/>	DO YOU PLAN TO HAVE CHILDREN	DO YOU TAKE HORMONES OR BIRTH CONTROL PILLS?
<input type="checkbox"/>	<input type="checkbox"/>	BREAST LUMPS	<input type="checkbox"/> YES <input type="checkbox"/> NO

**DRS. CITRON, CITRON & SPEAKER
315 E. Northfield Rd. 2A
Livingston, NJ 07039
973-535-3200**

**HEALTH INSURANCE PATIENT ACCOUNTABILITY ACT
(HIPPA)**

Drs. Citron, Citron and Speaker have always supported and recognized our patients' rights to expect that their medical records and other information about their care be kept confidential. The HIPPA privacy use and release of medical records, establish appropriate safeguards that all health care providers must achieve to protect the privacy of health information. They hold violators accountable with civil and criminal penalties if they violate patients' privacy rights.

One of the provisions of the HIPPA privacy regulations is that all health care providers distribute a "Notify of Privacy Practices". All patients can read this notice displayed in our waiting room. You are not required to read this notice, however, we are asking that you acknowledge having received access to this displayed notice by signing this acknowledgment statement.

Signature _____ Date _____

BARRY S. CITRON, M.D., F.A.C.S.

PLASTIC AND RECONSTRUCTIVE SURGERY
COSMETIC AND LASER SURGERY



Member

AMERICAN SOCIETY OF PLASTIC SURGEONS

FELLOW, AMERICAN
COLLEGE OF SURGEONS

MEMBER, NEW YORK
REGIONAL SOCIETY
OF PLASTIC AND
RECONSTRUCTIVE SURGERY

BOARD CERTIFIED
DIPLOMATE

AMERICAN BOARD
OF PLASTIC SURGERY

AMERICAN BOARD
OF SURGERY

AMERICAN BOARD
OF INTERNAL MEDICINE

Patient's Name: _____

AUTHORITY TO PHOTOGRAPH

I hereby grant to Dr. Barry S. Citron, M.D. the authority to take photographs or to have any photographs of the patient whose name appears above which may be necessary. I also grant authority to the above named physician to use the said photographs for any scientific presentations or publications.

INSURANCE AUTHORIZATION

I authorize Dr. Barry S. Citron, M.D. to release information, including but not limited to photographs, to the Social Security Administration, all private insurance companies or other carriers in regard to any claims filed by Dr. Citron on my behalf. I permit a copy of this authorization to be used in place of the original.

Signature of Patient, Parent or Guardian

Date

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FINANCIAL RESPONSIBILITY STATEMENT

The practice of Dr. Barry S. Citron, M.D., F.A.C.S., Plastic and Reconstructive Surgery is a separate business entity from Advanced Dermatology Associates, P.A. This practice does not participate in any insurance plans other than Medicare and PHS Healthnet. Therefore, for patients who are not enrolled in these plans, the payment of all fees is the responsibility of the patient. Upon request, all fees for your office visit or procedure will be discussed with you prior to consultation or surgery. After your office visit or surgery the statement will be provided for you to submit to your insurance company. Although many patients are reimbursed at or close to 100% of our fee schedule by their insurance plans, we cannot guarantee that you will be reimbursed at this or any level under the terms of your contract with your insurance company. You are responsible for determining if you have out of network coverage. If tissue is to be submitted to the pathologist for analysis, there will be additional charges billed by the pathologist and laboratory.

All fees are due and payable at the time of service.

By my signature below, I acknowledge that I have read, understood and agreed to the above terms and conditions. I agree that I will be financially responsible for all fees incurred.

Signature

Date

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