Danny Fong, MD, P.C.

Plastic & Reconstructive
Surgery of the Hand
212-343-9009
dannyfongmd@gmail.com
www.dannyfongmdpc.com

Patient Information **Date:**_____

Patient's Full Name: **Age**: ____ **Date of Birth:** ___ / ___ /___

_____ **Gender: M/F/Other** **Preferred Pronoun:** _____

Phone:_____ **Email Address:** _____

Home Address:

_____
STREET APT

_____
CITY STATE ZIP CODE

Pharmacy Info:

_____
NAME STREET

_____
CITY STATE ZIP CODE

Current Occupation:_____ **Retired: Yes/No**

Employer:_____

If Student, Name of School/University: _____ **City:** _____**State:** _____

Emergency Contact (*Required*): _____ **Relationship:**_____

Phone Number: _____

Primary Doctor: _____ **Referred By:**_____
FIRST NAME LAST NAME FIRST NAME LAST NAME

Has this office treated other member(s) of your family before: Yes___ No___

Name: _____

Bill paid by: Self ____ **Insurance**____ **Other**____

Primary Insurer:_____ **Relationship to patient:** _____

Date of Birth: _____ **Subscriber/Member ID#:**_____

(Please note, this practice does not accept no-fault or worker's compensation plans or policies)

PAST MEDICAL HISTORY
Please list all major surgeries, illnesses, and injuries:

_____

_____

MEDICATIONS CURRENTLY TAKEN

_____

_____

HEALTH QUESTIONS

Are you allergic to any drugs or medications? Yes___ No___
If yes, to what medication and describe the reaction: _____

Have you ever had a bad reaction to General Anesthesia? Yes___ No___

Have you ever had a bad reaction to Local Anesthesia? Yes___ No___

Do you have high blood pressure? Yes___ No___

Do you have diabetes? Yes___ No___

Do you have any heart conditions? Yes___ No___

Do you bleed unusually easily from cuts or surgery? Yes___ No___

Do you form large scars or keloids? Yes___ No___

Do you smoke? Yes___ No___

Do you consume alcohol regularly? Yes___ No___

Is your visit related to an injury at work or an auto accident? Yes___ No___

Your Height: _____ Your Weight: _____
When was your last physical exam: _____
Reason for today's visit:_____
Have you seen another plastic surgeon about this condition? Yes___ No___

I hereby authorize payment to be made directly to Danny Fong, M.D. for any medical or surgical benefits that he may be entitled to under my Medical-Surgical plans.
I understand that I am responsible for any balance due for my professional services in excess of benefits provided by my insurance policy.

X _____ _____ ___/___/___
Patient/Responsible Party Signature | Witness Signature (BY OFFICE STAFF ONLY) | Date