MEDICAL FACULTY ASSOCIATES

THE GEORGE WASHINGTON UNIVERSITY

MICHAEL OLDING, M.D. F.A.C.S.
2300 M STREET, NW
WASHINGTON DC 20037

Pt. Acct # for staff use only

DATE

EMAIL ADDRESS				CELL PHONE	
PATIENT NAME Last First Middle				DATE OF BIRTH	AGE
HOME ADDRESS	APT. NO.	CITY		STATE	ZIP
OCCUPATION	SS NUMBER	MARTIAL STATUS S M D W	SEX M F	HOME PHONE ( )	
EMPLOYER	ADDRESS			WORK PHONE ( )	
SPOUSE'S NAME (OR PARENT)		SPOUSE'S EMPLOYER (OR PARENT)		SPOUSE'S WORK PHONE (OR PARENT)	
IN CASE OF EMERGENCY, CONTACT:		RELATIONSHIP	WORK PHONE ( )	HOME PHONE ( )	
PRIMARY CARE PHYSICIAN					

BILLING INFORMATION

FINANCIALLY RESPONSIBLE PERSON SELF SPOUSE PARENT OTHER_____	NAME IF DIFFERENT FROM PATIENT	HOME PHONE ( )
FINANCIALLY RESPONSIBLE PERSON'S ADDRESS (IF DIFFERENT FROM PATIENT)		
FINANCIALLY RESPONSIBLE PERSON'S EMPLOYER	EMPLOYER ADDRESS	WORK PHONE ( )

INSURANCE INFORMATION

POLICY HOLDER SELF SPOUSE PARENT OTHER	PRIMARY INSURANCE CO. NAME		SUBSCRIBER'S NAME	
INSURANCE CO. ADDRESS		ID/POLICY NO.	GROUP NO	EFFECTIVE DATE/ EXPIRATION DATE
SECONDARY INS. CO & ADDRESS	SUBSCRIBER'S NAME	ID/POLICY NO.	GROUP NO	EFFECTIVE DATE/ EXPIRATION DATE

PATIENT'S AUTHORIZATION

I, _____, hereby authorize the MFA to apply for benefits on my behalf for covered rendered. I request payment from BC/BS of National Capital Area, Blue Shield of Maryland, and/or _____be
(other ins. Co. Name)
made directly to the MFA (or in the case of Medicare Part B benefits, to myself or to the party who accepts assignment).
I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to BC/BS of National Capital Area, the above named billing agent Blue Shield of Maryland (or in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration) and/or _____
I permit a copy of this authorization be used in place of the original. This authorization may be revoked by either me or above named carrier at any time in writing.

Signature of Subscriber or Benefactor Identification No. Date

Employee Signature Date

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AUTHORIZATION FOR EXAMINATION

Name: _____ Birthdate: _____
Address: _____ Soc. Sec Number: _____
_____ Home Phone: _____
City: _____ State: _____ Zip: _____ Work Phone: _____

Insurance: Yes ( ) No ( )

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I, _____, represent to the physicians and staff that I am at least 18 (eighteen) years of age, if not, am accompanied by a legal guardian.

I hereby consent to and authorize examination and treatment by my doctor and he may assign such assistant or staff as may be assigned by him/her.

I authorize the release of any medical information for the purpose of processing insurance claims on my behalf. I authorize payments of medical benefits directly to the doctor for services provided to me. A copy of this authorization shall be considered as valid as the original. I understand that photography is a necessary part of planning and evaluation cosmetic or reconstructive surgery. I authorize that taking of photographs at the direction of my surgeon and under such conditions as may be approved by him/her. Therefore, I consent to the having my picture taken for medical/patient education, insurance and rarely publications.

I understand that there may be a consultation fee for the initial visit, which is due at the Time of my appointment unless other arrangements have been made in advance.

Signature: _____ Date: _____

Relationship: (circle) Parent Spouse Guardian Other Self

Michael Olding, M.D.
Cosmetic/ Plastic Surgery

Patient Name:_____ Date:_____

Age: _____ Height: _____ Weight: _____ Occupation: _____

Reason for visit: _____Cell#_____ Home#_____

Who referred you to this office: _____

Who is your regular Medical Doctor: _____

Are you allergic, or have you reacted badly to:

1. Local Anesthetic …….. yes no
2. Penicillin …….. yes no
3. Codeine or other pain killers …… yes no
4. Aspirin ……. yes no
5. Others (please list) ……... yes no

……..……

Please list all medication which you are currently taking or have used in the past 6 months (be sure to include any of the following: birth control pills, aspirin, or ibuprofen containing drugs, diet pills, diabetic medications, steroids, glaucoma drops, asthma medications, Digoxin, Lanoxin, nitroglycerin, Isordil, Inderal, other heart medications, Lasix, other diuretics, high blood pressure medications, Coumadin, Persantine, tranquilizers, sleeping pills, anti-depressants, pain pills or shots, epilepsy medications).

Medication(s)	Amount	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you Bleed or Bruise easily? ……..… yes no

Are you a Smoker? yes no Ex-Smoker? yes no Non-Smoker? yes no
How much are (were) you smoking? _____ For how long? _____ Quit how long ago? _____

Please circle all of the following medical conditions you now have or have had in the past:

Bleeding Tendency	Hepatitis	Diabetes	Blood Transfusions	Glaucoma	Dry Eyes
Lung Disease	TB	Emphysema	Asthma or Wheezing	Bronchitis	Chest Pain
Heart Disease	Heart Attack	Stroke	Irregular Heart Beat	Epilepsy	Heart Burn
Intestinal Ulcers or Bleeding		High Blood Pressure		Depression	
Mental Illness	Drug or Alcohol Addiction		Any Other Serious Illness or Injury _____		

Is there any possibility that you may be pregnant at this time? yes no

List any surgeries that you have had (include plastic surgery):	Date:
_____	_____
_____	_____
_____	_____
_____	_____

Have you or anyone in your family ever had unusual reactions to anesthesia (muscle weakness, jaundice, breathing problems, or unexpected fevers)? yes no

Do you have (please circle all that apply): loose or chipped teeth / caps / dentures / contact lenses

Have you ever seen a cardiologist? yes no Physician Name:_____
Date of last EKG: _____

Patient Signature: _____ Date: _____