

# MEDICAL FACULTY ASSOCIATES

THE GEORGE WASHINGTON UNIVERSITY  
 MICHAEL OLDING, M.D. F.A.C.S.  
 2150 PENNSYLVANIA AVENUE  
 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		SEX	M	HOME PHONE
		S	M	D	W	( )
					F	
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		NAME IF DIFFERENT FROM PATIENT		HOME PHONE		
SELF	SPOUSE			( )		
PARENT	OTHER _____					
FINANCIALLY RESPONSIBLE PERSON'S ADDRESS (IF DIFFERENT FROM PATIENT)						
FINANCIALLY RESPONSIBLE PERSON'S EMPLOYER		EMPLOYER ADDRESS			WORK PHONE	
					( )	

### INSURANCE INFORMATION

POLICY HOLDER		PRIMARY INSURANCE CO. NAME		SUBSCRIBER'S NAME	
SELF	SPOUSE				
PARENT	OTHER				
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: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Work Phone: \_\_\_\_\_

Insurance: Yes ( ) No ( )

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: \_\_\_\_\_