



Andrew G. Goldberg, MD, FACS ● Mitchel D. Krieger, MD, FACS
3700 Joseph Siewick Drive, Suite 301, Fairfax VA, 22033
Telephone: 703-264-0904 ● Fax: 703-264-0906
www.virginiaplasticsurgery.com

Patient Information

Date _____ Physician (circle one) **Goldberg** / **Krieger**
Last Name _____ First name & Middle Initial _____
Address _____
City/State _____ Zip Code _____ Sex: Female / Male

Date of Birth _____ Age _____ Social Security # _____
Marital Status _____ Employer _____
Home Telephone _____ Work Telephone _____
Cell Phone _____
Email Address- By listing your email you give consent to be contacted by email _____

Primary Care Physician _____ Phone _____
Referring Physician _____ Phone _____

Referral Sources: Family/Friend Yellow Pages Magazine Website Physician Other _____

Emergency Contact _____ Relationship _____ Telephone _____

Responsible Party Information (Insurance Subscriber) if applicable and different from above

Last Name _____ First name & Initial _____
Address _____
City/State _____ Zip Code _____
Employer _____ Relationship to patient _____
Home Telephone _____ Work Telephone _____

Insurance Information if applicable

Primary Insurance _____
Subscriber's Name / SS# / Birth date _____
ID# _____ Group# _____ Copay _____

Secondary Insurance _____
Subscriber's Name / SS# / Birth date _____
ID# _____ Group# _____ Copay _____

Is injury work related /car accident Yes / No If yes please complete relevant portions of this section.

Date of injury _____ Claim # _____
Employer _____
Address _____ Phone _____
Workman's Comp Insurance Co. _____ Contact Person _____
Address _____ Phone _____

Auto Insurance Subscriber _____ Policy # _____
Auto Insurance Co _____ Contact Person _____
Address _____ Phone _____



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I HEREBY CONSENT TO THE FOLLOWING:

AUTHORIZATION

I hereby determine that I am under the care of Dr. Andrew Goldberg. or Dr. Mitchel Krieger hereafter referred to as my physician.

I authorize payment of medical benefits to my physician. I authorize my physician to release all medical records pertaining to medical history, services rendered or treatment for me or my dependents to my insurance company in order to receive payment for services provided to me. I acknowledge that I am financially responsible for any unpaid balance, deductible, co-insurance and co-payment. If my insurance policy is not effective at the time of service or the service is not covered, I will be held directly responsible for any fees incurred. I agree to pay my balance in full within 30 days from the date of the first statement or make payment arrangements with the office. If my account is forwarded to an outside collection agency I will be responsible to pay for additional collections fees.

I understand that I will pay for all cosmetic / self pay services in advance. If a claim for non-cosmetic self pay services is submitted to my health insurance carrier by me or my physician's office on my request, the amount of payment issued in excess of charges, if any, will be refunded to me.

PERMISSION FOR TAKING PHOTOGRAPHS

I hereby consent that photographs may be taken of me or the named patient by my physician in connection with medical care and treatment received.

I give / do not give (circle one) permission for my photographs to be used for educational or promotional purposes. I understand that I will not be entitled to monetary payment or any other consideration as a result of any use of these images.

CONSENT TO RELEASE AND HIPAA ACKNOWLEDGEMENT

I hereby authorize my physician or his representatives to discuss medical and payment information with

- 1. _____ Relationship _____
- 2. _____ Relationship _____

I acknowledge that I have had an opportunity to review a copy of my physician's notice of privacy practices. This notice describes how my physician may use and disclose my protected health information, certain restriction on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

Patient / Guardian Signature

Date



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MEDICAL HISTORY FORM

Date _____ Patient Name _____

Primary Care Physician _____ Reason for Today's Visit _____

Height _____ Weight _____ Age _____ Date of Last Tetanus Shot _____

Allergies: _____

Hospitalization/Surgery _____

Medical Conditions	Y	N	Y	N
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Skin Cancer	<input type="checkbox"/>
Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Other Cancer	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Type _____	
Heart Bypass / Angioplasty	<input type="checkbox"/>	<input type="checkbox"/>	Stroke/Nerve Function	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>
Asthma/Breathing Problems	<input type="checkbox"/>	<input type="checkbox"/>	Visual Difficulties	<input type="checkbox"/>
Family History of Melanoma	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/Liver/Intestinal	<input type="checkbox"/>
Fever/Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	Kidney/Urinary	<input type="checkbox"/>
Muscle/Joint Pain or Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	Breast	<input type="checkbox"/>
Easy Bruising/Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Blood Circulation	<input type="checkbox"/>

Medication list (please include any over the counter drugs, vitamins or homeopathic remedies)

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

Do you take Aspirin daily? Yes or No
Do you use alcohol? Never _____ Socially _____ Daily _____
Do you smoke? Yes or No If yes how much per day? _____

Date of Last Mammogram _____ Family History of Breast Cancer? Yes or No
History of Pregnancy _____ Breast Feeding? Yes or No

Occupation _____ Who lives in Household? _____

Have you consulted with other plastic surgeons? _____



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Medicare/Medigap Authorization

I hereby determine that I am under the care of Dr. Andrew G. Goldberg or Dr. Mitchel D. Krieger hereafter referred to as my physician.

Patients Name _____

Birth Date _____ Social Security # _____

I request that payment of authorized Medicare benefits be paid to either me or on my behalf to my physician for services furnished to me by my physician or his representatives.. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Medigap insurance _____

Address _____ Telephone _____

ID # _____ Group# _____

Subscriber's Name _____ Subscriber Social Security # _____

I request that payment of authorized Medigap benefits be made either to me or on my behalf to my physician. I authorize any holder of Medicare information about me to release to (Insurance Co.) _____ any information needed to determine these benefits payable for related services.

Patient / Guardian Signature

Date



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Insurance Coverage Information

Due to the constant changes in insurance policies we are unable to verify your insurance coverage, deductibles, and co-payment amount before the start of each service. It is your responsibility to be informed about your own insurance policy, co-payment amount and deductible. To avoid problems please verify with your insurance carrier your financial obligations seeing both in-network and out of network providers. If you have a managed care plan you are responsible for obtaining a referral from your PCP. If your referral is not provided at the time of service, your appointment will need to be rescheduled or you will be responsible to pay for the services provided.

The following is a list of insurance companies your doctor is contracted with.

Dr. Goldberg: Carefirst,
Bluechoice (HMO)
BC/BS of Virginia Anthem (PPO)
Healthkeepers
Medicare

Dr. Krieger: Carefirst
Bluechoice (HMO)
BC/BS of Virginia Anthem (PPO)
Medicare

PPO/Third Party Insurance- Please verify your coverage with your insurance company. Due to continuing changes in contracts and names of insurance carrier, we will submit claims to all carriers for you. If your insurance plan is not listed, your doctor may still be able to provide care if you have out of network benefits. Please contact your insurance carrier to determine your out of network benefits as they may differ from your in network benefits.

The above information was provided to me before the initial service started if any part of the information was not clear to me the staff explained it. I accept my financial responsibilities.

Patient / Guardian Signature

Date