

Out of State or International Scarless Breast Reduction Consultation

Thank you for your inquiry regarding Liposuction Breast Reduction by Dr. Gray. In order for us to review your condition and symptoms and review insurance authorization, please complete the following information:

Name of Patient: _____

Mailing Address: _____

City/State/Zip: _____

Phone: _____

Email: _____

Date of Birth: _____

Height: _____ Weight: _____ Bra Size: _____

Circle if you have any of the following symptoms:

Back Pain Neck Pain Shoulder Pain Headaches
Hand Numbness Skin Irritation Breast Pain

Other (please explain): _____

If you have had medical treatment for any of these conditions, please explain: include any medications, chiropractic or physical therapy treatments, and the physician that diagnosed the same.

Date of last Mammogram (within the year): _____

Have you tried an exercise program? _____. Did you loose any weight? _____.

If so, how much? _____. Did your breast size change? _____.

Have you taken any anti-inflammatory medication? _____.

Fax, email or send the above information to:

Attn: Dr. Lawrence Gray
 Out of Town Consultation

Fax: 603-427-2540
Email: DRLGRAY@ATLANTICPLASTICSURG.COM

Address: Atlantic Plastic Surgery Center
 100 Griffin Road, Suite B
 Portsmouth, NH 03801

Phone: 800-633-6860

WEB: www.atlanticplasticsurg.com

INSURANCE INFORMATION (if applicable)

PLEASE CALL OUR OFFICE PRIOR TO COMPLETING BELOW TO VERIFY THAT WE ARE PARTICIPATING WITH YOUR INSURANCE COMPANY

If you have any medical records from your primary care physician or other physicians who have treated you for any of the above conditions, it would be helpful to send copies of these records if we submit this to your insurance company. If applicable, please forward them to our office.

Insurance Information:

Subscriber: _____

Subscriber's SS#: _____

Name of Insurance: _____

Address: _____

City/State/Zip: _____

Phone#: _____