

# Out of State or International Scarless or Conventional Breast Reduction Consultation

Thank you for your inquiry regarding breast reduction by Dr. Gray and Dr. Claytor. In order for us to review your condition, symptoms, and 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

Hand Numbness              Skin Irritation Breast Pain      Headaches

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 diagnosing physician.

\_\_\_\_\_  
\_\_\_\_\_

Date of last Mammogram (within the year): \_\_\_\_\_

Have you tried an exercise program? \_\_\_\_\_ Did you lose any weight? \_\_\_\_\_

If so, how much? \_\_\_\_\_ Did your breast size change? \_\_\_\_\_

Have you taken any anti-inflammatory medication? \_\_\_\_\_.

***Fax, email or mail the above information to:***

Attn: Patient Co-ordinator  
Out of Town Consultation

Fax: 603 - 427 - 2540

Email: [DRLGRAY@ATLANTICPLASTICSURG.COM](mailto:DRLGRAY@ATLANTICPLASTICSURG.COM)

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

Phone: 800-633-6860

WEB: [www.atlanticplasticsurg.com](http://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, please forward them to our office.

Insurance Information:

Subscriber: \_\_\_\_\_

Subscriber's SS#: \_\_\_\_\_

Name of Insurance: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone#: \_\_\_\_\_