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

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, please forward them to our office.

Insurance Information:

Subscriber: _____

Subscriber's SS#: _____

Name of Insurance: _____

Address: _____

City/State/Zip: _____

Phone#: _____