MARK H. SCHWARTZ, M.D., F.A.C.S
DIPLOMATE, AMERICAN BOARD OF PLASTIC SURGERY
79 EAST 79TH STREET
NEW YORK, NY 10075

Name ______________________________
Last First Middle
Address ______________________________
City, State, Zip ______________________________
Home Telephone ______________________________
Mobile Phone ______________________________
Date of Birth ______________ Age ________
Social Security No. ______________________________
Employer ______________________________
Employer Address ______________________________
Business Telephone ______________________________
Occupation ______________________________
Email Address ______________________________
Marital Status (optional) ______________________________
Referring Physician/Other ______________________________

Please complete if responsible party is different from patient:

Name ______________________________
Last First Middle
Address ______________________________
City, State, Zip ______________________________
Home Telephone ______________________________
Mobile Phone ______________________________
Date of Birth ______________ Age ________
Social Security No. ______________________________
Employer ______________________________
Employer Address ______________________________
Business Telephone ______________________________
Occupation ______________________________
Relationship to Patient ______________________________

Person to contact in case of an emergency:

Name ______________________ Telephone ______________________

INSURANCE INFORMATION

Primary Insurance company	Secondary Insurance Company
Address	Address
City, State, Zip	City, State, Zip
Policy Holder	Policy Holder
Identification #	Identification #
Policy Group #	Policy Group #

Is this visit for a work-related injury or an automobile accident? ______________________________

We request that payment be made at the time services are rendered unless other arrangements have been made.

To All Patients

I hereby assign all surgical and/or medical benefits, to include major medical benefits to which I am entitled, including private insurance, Medicare, and any other health plans to Dr. Schwartz and I understand that I am financially responsible for any unpaid balance. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize Dr. Schwartz to release all information necessary to secure assignment. I also understand that I will be responsible and agree to pay attorneys fees which is equal to 1/3 of the total balance plus any processing fees that might be incurred to collect payment in full. I have received or reviewed the "Notice of Privacy Practices for Protected Health Information" as required by the Health Insurance Portability and Accountability Act of 1996 and it is also available for review and is posted in the office.

______________________________ ______________________
Signature of Patient/Responsible Party Date

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CONFIDENTIAL MEDICAL HISTORY

Reason for consultation ______________________________

Height ________ Weight ________ Recent Changes in Weight (+) ________ (-) ________

Allergies or reactions to medications or anesthetics ______________________________

Please list any medications you are currently taking ______________________________

____

Are you currently taking any of the following?

☐ Aspirin ☐ Motrin ☐ Advil ☐ Anti-inflammatory/anti-arthritic medications ☐ Steroids/Prednisone

☐ Vitamin Supplements, homeopathic medicine or natural food supplements

Please indicate when last taken ______________________________

Do you or have you ever smoked? ☐ Yes ☐ No

If yes, how many packs per day? ____ For how many years? ____ If you quit, when? ________

How much alcohol do you drink on a weekly basis? ______________________________

Do you have a history of excessive bleeding? ☐ Yes ☐ No

Have you ever had a blood transfusion? ☐ Yes ☐ No

Do you have a history of a heart murmur? ☐ Yes ☐ No

Do you have a history of keloids/abnormal scars? ☐ Yes ☐ No

Please check if you have any medical problems listed below:

☐ Diabetes ☐ Thyroid/Endocrine ☐ Kidney/Bladder ☐ Vascular
☐ High Blood Pressure ☐ Eyes/Glaucoma ☐ Musculoskeletal ☐ Respiratory
☐ Breast Disease ☐ Ears/Throat ☐ Psychiatric ☐ Neurologic
☐ Heart Disease ☐ Nose ☐ Infectious Disease/HIV ☐ Stomach/Gastrointestinal

If female: ☐ Gynecologic/Pregnancy problems Are you currently pregnant? ☐ Yes ☐ No
If male: ☐ Urologic/Prostrate problems

If yes to any of the above, please explain: ______________________________

____

____

Do you have a family history of any medical problems or illnesses? ______________________________

When was your last tetanus shot? ______________________________

Any previous surgery? ______________________________

Any previous hospitalizations? ______________________________