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 _____

Pharmacy Name _____

Pharmacy Number _____

Person to contact in case of an emergency:

Name _____ Telephone _____

INSURANCE INFORMATION

Primary Insurance company

Address

City, State, Zip

Policy Holder

Identification #

Policy Group #

Secondary Insurance Company

Address

City, State, Zip

Policy Holder

Identification #

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? _____