

**Mark B. Schoemann, M.D.**  
DIPLOMATE, AMERICAN BOARD OF PLASTIC SURGERY  
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PLASTIC AND AESTHETIC SURGERY  
RECONSTRUCTIVE SURGERY

XIMED MEDICAL BUILDING  
9850 GENESEE AVENUE, SUITE 500  
LA JOLLA, CA 92037  
(858) 450-1776 FAX (858) 450-9446

**Confidential information required for our case history file. Please answer each question.**

Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_

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

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

Social Security #: \_\_\_\_\_ Driver License #: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Work Number: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_

Marital Status: S M D W Sep. Email Address: \_\_\_\_\_

Preferred Contact Method: ( ) Home ( ) Cell ( ) Email ( ) Text message

Spouse Name (or parent if minor) and Phone: \_\_\_\_\_

Patient Employed By: \_\_\_\_\_ Occupation: \_\_\_\_\_

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

What would you like to achieve with plastic surgery? \_\_\_\_\_

What time frame are you considering for surgery? ( ) As soon as possible ( ) 1 – 3 months

( ) 4 – 6 months ( ) 6 – 12 months ( ) Just need information

Are you interested in financing? Yes \_\_\_\_\_ No \_\_\_\_\_

Who may we thank for referring you to our office? \_\_\_\_\_

Emergency Contact Name and Phone Numbers: \_\_\_\_\_

Do you have medical health insurance? Y ( ) N ( ) Insurance carrier: \_\_\_\_\_

Are you presently or have you recently been under the care of any other physicians? Who is your family doctor or internist? Please list.

Name: \_\_\_\_\_ Address: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

\_\_\_\_\_  
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