ROBERT SCHWARTZ PLASTIC SURGERY

PATIENT INFORMATION

(PLEASE PRINT)

Name _____ Date _____

Responsible Party (if patient is a minor) _____

Sex: ☐ M ☐ F Age _____ Birth date _____ ☐ Single ☐ Married ☐ Widowed

Social Security Number _____ ☐ Separated ☐ Divorced

Occupation _____ Employer (if student, name of school) _____

Spouse's Name _____ Children's Names _____

How were you referred to our practice? _____

CONTACT INFORMATION

Home Address ☐ This is my mailing address

_____ _____ _____ _____
Street City State Zip

Business Address ☐ This is my mailing address

_____ _____ _____ _____
Street City State Zip

Home Phone _____

Work Phone _____

Mobile Phone _____

Pager _____

Emergency Contact

Name _____

Phone _____

Relationship to patient _____

Pharmacy Name _____ Pharmacy Phone _____

E-mail:

Email #1 _____

Email #2 _____

Website _____

Twitter @_____

IMPORTANT: E-Mail Authorization

By providing us with your email address, you are authorizing us to communicate with you at that address. Please only list email addresses at which you are comfortable receiving email from us. For example, you may not want to give us your email address at work if it is not private. Also, please be aware that email is not a completely secure medium and email sent could be intercepted by malicious internet users (hackers). Though this is unlikely, it is possible and is beyond our control.

Primary Physician

Name _____ City _____ State _____

Specialty _____

Other Physicians seen in last 5 years

#1

Name _____ City _____ State _____

Specialty _____ Reason for seeing _____

#2

Name _____ City _____ State _____

Specialty _____ Reason for seeing _____

#3

Name _____ City _____ State _____

Specialty _____ Reason for seeing _____

FINANCIAL INFORMATION ***Medical Insurance***

Primary Insurer

Insurer Name _____ Phone _____

Policy # _____ Group # _____ Contract # _____

Secondary Insurer

Insurer Name _____ Phone _____

Policy # _____ Group # _____ Contract # _____

ASSIGNMENT AND RELEASE

I, the undersigned, assign directly to Dr. Schwartz all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic. I authorize the release of all information necessary to secure the payment of fees not covered by insurance including all fees related to cosmetic procedures. In order to secure financing for my procedure or to collect a debt related to my account, all necessary information may be released to cosmetic surgery finance companies, my credit card issuer(s), collection agencies or other relevant financial institutions.

_____ _____

Signature of Insured / Guardian Date

FINANCIAL POLICIES

1. Fees for consultation, office procedures, and aesthetician services are payable at the time services are rendered. These fees are non-refundable.
2. For operating room procedures, payment of the surgeon's fee is required at the time surgery is scheduled.
3. All remaining operating room, anesthesia, and supply fees are due at least one month prior to surgery.
4. Cancellation of surgery less than one month before the procedure date will result in forfeiture of 75% of the surgeon's fee. Cancellation one month or more before the procedure date will result in forfeiture of 50% of the surgeon's fee. Operating room, anesthesia, and supply fees are always fully refundable.
5. A fee of 10% of the total surgery invoice will be charged for rescheduling surgery less than one month before the surgery date.
6. Accepted forms of payment are cash, check, money order, and credit card. We accept Visa, Master Card, American Express, and Discover cards.

_____ _____

Patient's Signature Date

Robert J Schwartz MD PA

Authorization of Use and Disclosure of Protected Health Information

Appointment Reminders. The practice may use your information to remind you about upcoming appointments. Appointment reminders are either sent by mail in a sealed envelope, via email or, by a brief, non-specific message left on your answering machine. Occasionally, we may also use "appointment cards" to remind you about upcoming appointments. Our appointment reminders do not include any specific details as to the nature of your appointment nor do they contain any of your private health care information. By signing below, you acknowledge that you understand and accept our appointment reminder policies.

Other Uses and Disclosures. Disclosure of your health information or its use for any purpose other than those listed in the "Notice of Privacy Policies and Practices" brochure and / or consent require your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision. You have the right to request restrictions on use and disclosure of your health information.

Persons Authorized to Receive Information:

Health information **Robert J Schwartz MD PA** collects or receives about you may be disclosed to the following persons:

_____ _____

Name of person / relation / organization Name of person / relation / organization

_____ _____

Name of person / relation / organization Name of person / relation / organization

Use of Email: At Robert J Schwartz MD PA, we use email to communicate with some of our business associates (e.g. surgery center, anesthesia provider) in order to schedule your surgery. These emails may contain protected health information such as the type of surgery you are going to have. Your signature at the end of this document authorizes us to use email in this manner.

Right to Terminate or Revoke Authorization: You may revoke or terminate this authorization by submitting a written revocation to Robert J Schwartz MD PA. You should contact the OFFICE MANAGER or other authorized representative to terminate this authorization.

Potential for Re-disclosure: The person or organization to which health information is sent may repeatedly disclose health Information that is identified by this authorization. The privacy of this information may not be protected under the federal privacy regulations.

Expiration: This authorization will expire on the date on which the existence of Robert J. Schwartz, M.D., P.A. is terminated.

_____ _____

Name of Patient (Print or Type) Date

_____ OR: _____

Signature of Patient Signature of Patient Representative

I have been given the opportunity to read and obtain a copy of ***NOTICE OF PRIVACY POLICIES AND PRACTICES.***

_____ _____

Patient Signature Date

HEALTH HISTORY
(Confidential)

Today's Date_____ Name_____

Age_____ Birth date_____ Date of last physical examination_____

What is your reason for visit?_____

SYMPTOMS / CONDITIONS Check (✓) symptoms or conditions you currently have or have had in the past.

- ☐ Abnormal Pap Smear
- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding between periods
- ☐ Bleeding Disorders
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Breast Lump
- ☐ Breast lump
- ☐ Bronchitis
- ☐ Bruise easily
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Change in moles
- ☐ Chemical Dependency
- ☐ Chest pain
- ☐ Chicken Pox
- ☐ Chills
- ☐ Depression
- ☐ Diabetes
- ☐ Dizziness
- ☐ Double vision
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Hay fever
- ☐ Headache
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High blood pressure
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Hives
- ☐ Hoarseness
- ☐ Hot flashes
- ☐ Irregular heart beat
- ☐ Itching
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Low blood pressure
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Nerve Injury
- ☐ Nervousness
- ☐ Nipple discharge
- ☐ Nosebleeds
- ☐ Numbness
- ☐ Pacemaker
- ☐ Persistent cough
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rapid heart beat
- ☐ Rash
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Scars
- ☐ Sore that won't heal
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Sweats
- ☐ Swelling of ankles
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Urinary Tract Infections
- ☐ Vaginal Disease
- ☐ Vaginal Infections
- ☐ Varicose veins

Date of last menstrual period_____

Date of last Pap Smear_____

Have you had a mammogram?_____

Are you pregnant?_____

Number of children_____

MEDICATIONS List medications you are currently taking	**ALLERGIES** To medications or substances
Pharmacy Number:	

FAMILY HISTORY Fill in health information

Relation	Age	State of Health	Age at Death	Cause of Death	Check (✓) if, your blood relatives had any of the following: Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer	
					Chemical Dependency	
					Diabetes	
					Heart Disease, Strokes	
Sisters					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

PAST SURGERIES

Year	Hospital	Reason for Hospitalization and Outcome

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

If yes, please give approximate dates:

SERIOUS ILLNESS/INJURIES	DATE	Other

PREGNANCY HISTORY

Year of Birth	Sex of Birth	Complications if any

HEALTH HABITS

Check (✓) which substances you use and describe how much you use.

	Caffeine	
	Tobacco	
	Drugs	
	Alcohol	

OCCUPATIONAL CONCERNS

Check (✓) if your job exposes you to the following:

	Stress
	Hazardous Substances
	Heavy Lifting
	Other
	Your occupation:

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Signature Date

_____ _____

Reviewed By Date