MATTHEW SCHULMAN M.D.

BOARD CERTIFIED PLASTIC SURGEON

MATTHEW SCHULMAN, M.D., P.C. 62 E 88th Street, LL, Suite C. New York, NY 10128 ph: 212.289.1851

Patient Information

Date _____

Name: _____

Gender: __M __F Age: ____ Birthdate (month/date/year): _____ Social Security: _____

Address: _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email address _____

(This is for correspondences from this office only. We will not share your email with anyone else)

Marital Status: __Single __Married __Divorced __Widowed __Separated

Race: (check all that apply) __Black __Caucasian __Asian __Hispanic __Other_____

Occupation: _____ Employer: _____

Primary Care Physician: _____ Phone: _____

Emergency Contact:

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Parent /Guardian Information (to be completed only if the patient is a minor - under 18)

Name: _____ Relationship_____

Home Phone _____ Cell Phone _____ Work Phone _____

Procedure you are interested in: _____

What stage are you in the consultation process?

- I am gathering information
- I am sure I want the procedure; I'm selecting the correct doctor for me
- I know I want Dr. Schulman as my surgeon

I am interested in having my procedure: (month/year) _____

I am interested in learning more about financing my procedure (circle one) Yes No

How did you hear about us? Please be as specific as possible

__Friend: _____
__Dr. Schulman's patient: _____
__Magazine/Newspaper: _____
__Television Show: _____
__Realself.com
__Drschulmanplasticsurgery.com
__Internet (Google/Yahoo): _____
__Instagram
__Snapchat
__Physician referral (name of Physician): _____
__Other: _____

If media opportunities arise related to your procedure, would you be interested in appearing on TV? (Circle One) Yes No Maybe

Personal Medical History: Please mark all past and present medical conditions:

Cardiovascular:
__High blood pressure
__Heart attack(s)
__Pacemaker
__Coronary artery disease
__Murmur / Mitral valve prolapse
__Irregular heartbeat / palpitations
__Other: _____

Pulmonary:
__Asthma
__Chronic lung disease
__Chronic cough
__Shortness of breath
__Other: _____

Neuromuscular:
__Arthritis
__Muscle weakness
__Nerve damage
__Facial paralysis / Weakness
__Headaches
__Seizure disorder / Convulsions
__Spinal / Back disorders
__Other: _____

Psychological:
__Depression
__Anxiety
__Claustrophobia
__Drug/Alcohol dependency
__Psychiatric hospitalization
__Other: _____

Nose:
__Difficulty breathing by nose
__Previous nasal injury / fracture
__History of sinus infections
__Other: _____

Eyes:
__Dry eye
__Blurred / Double vision
__Glaucoma
__Wears glasses or contacts
__Other: _____

Endocrine:
__Diabetes
__Thyroid disease
__Lupus
__Other: _____

Renal:
__Renal failure
__Dialysis
__Other: _____

Hematology:
__Blood transfusion
__Bleeding disorder
__Anemia
__Other: _____

Gastrointestinal:
__Colitis
__Reflux / ulcer disease
__Other: _____

Immunologic / Infectious:
__HIV / AIDS
__Hepatitis (Type_____)
__Sexually transmitted disease
__Tuberculosis (TB)
__Auto-immune disorder
__Other: _____

Dermatological:
__Excessive sweating
__Cold sores / herpes
__Acne
__Rosacea
__Eczema
__Psoriasis
__Scarring / Keloid formation
__Other: _____

Cancer:
__Basal cell cancer
Location: _____
__Squamous cell cancer
Location: _____
__Melanoma
Location: _____
__Breast cancer
__Ovarian cancer
__Lung cancer
__Colon cancer
__Prostate cancer
__Other: _____

Please list any other conditions not listed above: _____

Personal Surgical History

Surgical Procedure	Date	Surgeon

Have you ever had any surgical complications? __Yes __No

If yes, please describe: _____

Medications

List all medications you are currently taking, including prescriptions, over-the-counter treatments, vitamins, herbal supplements and creams. Please let us know the reason you are taking each medication.

Name of Medicine	Dose and Frequency	Reason

Have you been on Accutane therapy within the past 24 months? __Yes __No

Allergies

Medication allergies? __Yes __No
If yes, please list the medication and the type of reaction _____

other allergies (seasonal, adhesive tape, seafood, etc.)_____

Social History

Do you smoke? ____No ____Yes (# per day: _____) _____I did, but I quit (date: _____)

Do you drink alcohol? ____No ____Yes (#of drinks per week_____)

How often do you exercise? ____Daily _____1 x per week _____2-3 x per week ____4-6 x per week

Children

How many pregnancies_____ How many children_____ Ages _____

Weight and Height

Current weight _____ Current height _____

Authorization To Treat

I authorize medical treatment and agree to pay all fees and charges for treatments and services rendered. I understand that medical treatment may include a review of personal, social and medical history, discussion of the reason(s) for the visit(s), and may include photographs of the area(s) being discussed and/or treated before and/or after treatment. I authorize a copy of this document to be used in place of the original.

Signature: _____ **Date:** _____

PRIVACY PRACTICE AND ACKNOWLEDGMENT

♦ I agree that I can be contacted regarding my appointments, prescription renewals, lab results, and all other **Protected Health Information ("PHI"),** at the telephone numbers provided.

♦ I understand that it is your policy not to reveal Protected Health Information ("PHI") on voicemail systems and answering machines, except for appointment reminders

♦ I understand that it is your policy to email information and confirmation messages to the email address(es) I provided you. I also understand that this method of communication is not intended to communicate "PHI" with you.

♦ I understand that it is your policy, in compliance with the law, to reveal "PHI" with my other physicians.

♦ I understand that it is your policy not to reveal "PHI" to my spouse, unless I enter his/her name below.

♦ I agree that my "PHI" may be shared with the following other people (please indicate relationship):

_____ ph (__ __ __) __ __ __ - __ __ __ __

_____ ph (__ __ __) __ __ __ - __ __ __ __

♦ I understand that it is your policy that, when you receive telephone calls to discuss my medical care or test results, all callers, including myself, will have to supply information that uniquely identifies me, such as the last 4 digits of my social security number and/or my birth date, and that without such a match no "PHI" will be revealed.

♦ I understand that I can change any of the abovementioned agreement, at any time, by giving written notice.

I have read and understand the information above as it pertains to my privacy.

Patient Name (print):_____

Signature: _____ **Date:** _____

If the patient is a minor, the responsible parent or guardian must sign above, and fill in the information below.

Parent/Guardian Name (print): _____ **Relationship** _____

FINANCIAL AGREEMENT, CANCELLATION POLICY and CHARGE DISPUTE

I agree that I am responsible for all charges incurred at this office (you will be made aware of any charges prior to receiving any treatment). I acknowledge that your cancellation policy requires 24 hour notice for any appointment cancellations or rescheduling of my visits after my initial consultation. If I do not give adequate notice, a $75 charge will be made to my credit card that is on file. This charge is considered valid and authorized without a signed charge slip. If a valid credit card is not on file, I will be billed, and will pay this bill. All outstanding balances must be paid prior to be given another appointment. I agree that any dispute regarding any charges will be addressed with Dr. Schulman's Office directly and not my bank or credit card company. This specifically means that I will not attempt to resolve my dispute by reversing any credit card charges or canceling any checks.

I am aware of the above policies and am in agreement.

Patient Name (print): _____

Patient Signature: _____ **Date:**_____