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: ____
City, State, Zip Code

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 (@nycplasticsurg)
__Snapchat (nycplasticsurg)
__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 the consultation fee is for the service of consultation and is nonrefundable under any circumstances. I acknowledge that your cancellation policy requires **48-hour notice for any appointment cancellations or rescheduling** of my visits after my initial consultation. If I do not give adequate notice, the consultation fee will be charged to my credit card that is on file. If I arrive more than 15 minutes late to my scheduled appointment, I understand that I am not guaranteed to be seen and will be charged the late/cancellation fee. 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:**________________

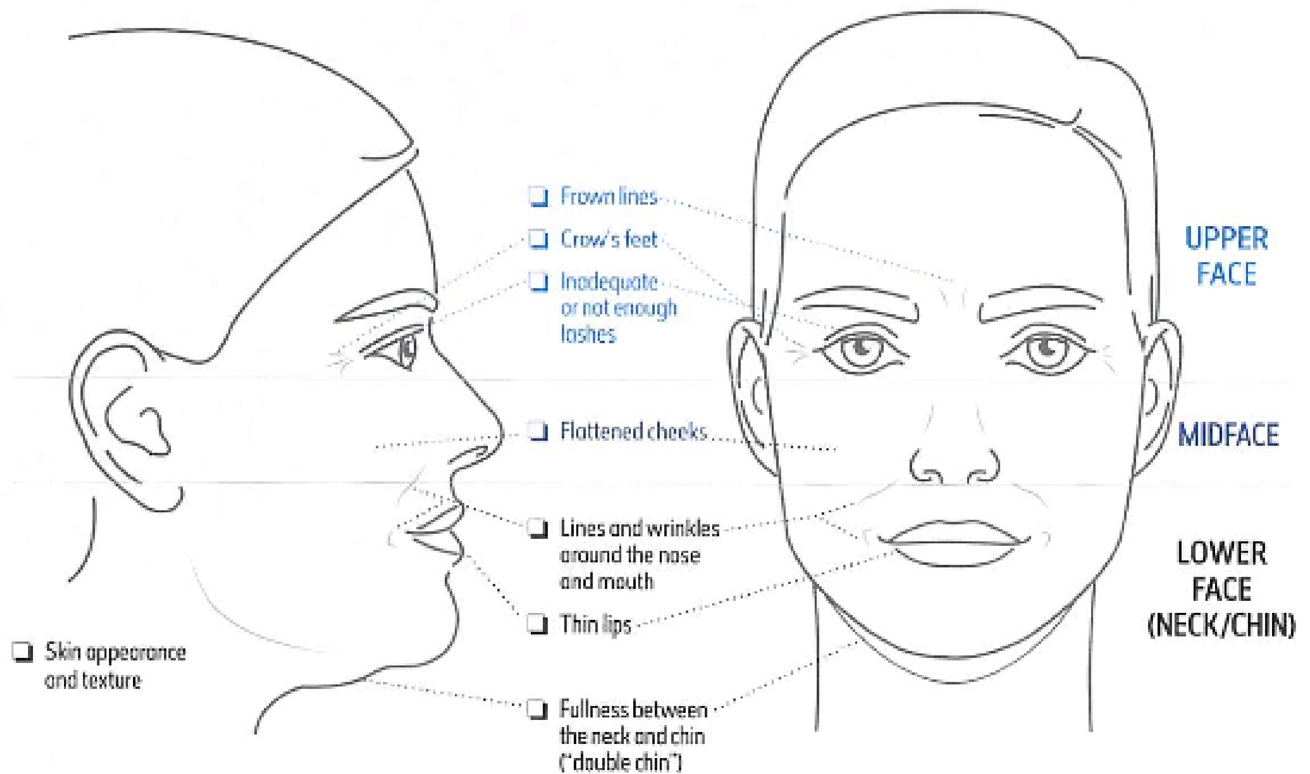
SELF-ASSESSMENT

NAME: ______________________ DATE OF BIRTH: ______________ DATE: ______________

What brings you in today? ______________________________

Select which areas of the face concern you on the diagram below.

By sharing how you see yourself, we can best evaluate your aesthetic goals and select an appropriate treatment for you.



Please complete and return this form to the front office before your consultation.

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