SCHUSTER AND SCHREIBER, P.A.

RONALD H. SCHUSTER, M.D. **JEFFREY E. SCHREIBER, M.D.**

DATE_____

NAME (last, first, middle):_____

ADDRESS: _____ APT #:_____

CITY: _____ STATE: _____ ZIP CODE: _____

DATE OF BIRTH: _____

HOME PHONE: (_____)_____WORK PHONE:(_____)_____

CELL PHONE: (____)_____ E-MAIL ADDRESS: _____

MARITAL STATUS: M _____ W _____ S _____ D _____ SEP _____

PARENTS (if patient is a child): MOTHER: _____ FATHER: _____

GENDER ID:_____ RACE:_____ AGE: _____

HOW DID YOU HEAR ABOUT OUR PRACTICE? _____

WHO IS YOUR PRIMARY CARE? _____OFFICE #_____

PHARMACY: _____ADDRESS_____PHONE:_____

OCCUPATION:_____

EMPLOYER: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

EMERGENCY CONTACT: _____ HOME #:_____

RELATIONSHIP: _____CELL #: _____ WORK #:_____

Reshaping Your Image
Schuster & Schreiber
PLASTIC SURGERY & SKINCARE

Sign to receive our Newsletter & Specials! _____

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RONALD H. SCHUSTER, M.D. JEFFREY SCHREIBER, M.D.

HIPAA POLICY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I HAVE RECEIVED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES.

Please Print Name: _____

Signature: _____ Date:_____

I GIVE PERMISSION TO RELEASE MY MEDICAL INFORMATION TO THE FOLLOWING:

_____ mother _____ father _____ spouse

_____ other (specify)_____

_____ _____
Signature Date

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (Please Specify)_____

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WAIVER OF LIABILITY:

Your insurance will only pay for services that it determines to be reasonable and necessary. Reasonable effort is made by this office to comply with the guidelines set forth by your insurance company. If your insurance determines that a particular service is not reasonable and necessary under their program standards, your insurance will deny payment for that service. Your insurance may deny payment stating that the service was not medically necessary or that it is cosmetic in nature. Schuster & Schreiber MD PA charges 12% interest on all accounts past 30 days. Should I default in payment, I agree to pay all cost of collections, including collection agency fees, court costs and any reasonable attorney fees up to 35% of the outstanding balance. I authorize Schuster & Schreiber MD PA to apply for benefits on my behalf for services rendered, and request that payment form my insurance company be made directly to Schuster & Schreiber MD PA.

Payment may be denied for the services identified above, for the reason(s) stated. If your insurance denies payment, you agree to be personally and fully responsible for payment.

_____ _____
Patient Signature Date

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PERSONAL MEDICAL HISTORY EVALUATION

NAME: _____AGE: _____ DATE: _____

Areas of concern (procedure of interest)?_____

Please list all current medications and dosages:

Please list all allergies:

Please list previous surgery and date:

Do you have or have you had: **(circle)**

High blood pressure	Y/N	Headaches/migraines	Y/N
Heart attack	Y/N	Dizziness	Y/N
Angina/chest pain	Y/N	Seizures	Y/N
Palpitations/arrhythmias	Y/N	Stroke	Y/N
Mitral Valve Prolapse	Y/N	Weakness	Y/N
Rheumatic fever	Y/N	Numbness	Y/N
Heart Surgery	Y/N	Anxiety/nervousness	Y/N
Sinusitis	Y/N	Stomach ulcers	Y/N
Shortness of breath	Y/N	Diarrhea/Constipation	Y/N
Pneumonia/T.B.	Y/N	Hepatitis	Y/N
Bronchitis/Asthma	Y/N	Diabetes	Y/N
Thyroid problems	Y/N	Lupus/arthritis	Y/N
Cancer	Y/N	Problems w/ circulation	Y/N
of what? _____		Problems w/ kidneys	Y/N

Do you have a history of bleeding, hemorrhage, or bruising easily? Y/N

Have you ever been diagnosed with sleep apnea? Y/N

Do you have a history of substance abuse? Y/N

Do you take aspirin regularly? Y/N

Have you ever received a blood transfusion? Y/N If yes, when? _____

Occupation:_____ Do you have children? _____ How many? _____

Do you drink alcohol? Y/N How much? _____

Do use tobacco? Y/N Marijuana? Y/N If yes, how much?_____

Family History of Illness (cancer, diabetes etc.):_____