HARA J. SCHWARTZ, M.D.

Aesthetic & General Dermatology

Last Name_____First Name_____Middle Initial_____

Mailing Address_____

City_____State_____Zip Code_____

Home Phone_____Work Phone_____Cell Phone_____

Birth Date_____Age_____SS #_____

E-Mail Address_____

Female_____Male_____ Married_____Single_____Divorced_____Widowed_____

Occupation_____Employer Name_____

Pharmacy_____ Zip Code_____

In case of emergency, contact:_____Phone_____Relationship_____

Referred by_____City_____State_____Zip_____

Primary Insurance_____Policy#_____Group#_____

Insured's name (if not the same): Last_____First_____Middle Initial_____

Street Address_____

City_____State_____Zip Code_____

Patient's relation to insured: Self_____Spouse_____Child_____Other_____

SS# of Policy Holder (if different from patient)_____DOB of Policy Holder_____

Secondary Insurance _____Policy #_____Group #_____

Insured's name (if not the same): Last_____First_____Middle Initial_____

Street Address_____

City_____State_____Zip Code_____

Patient's relation to insured: Self_____Spouse_____Child_____Other_____

SS# of Policy Holder (if different from patient)_____DOB of Policy Holder_____

400 Westage Business Center, Suite 203 • Fishkill, NY 12524 • TEL: 845.896.5140 • FAX: 845.896.5144

Medicare Patients Only: I authorize any holder of medical or other information about me to release to the Social Security Administration and the Centers for Medicare and Medicaid Services or their intermediaries or carriers, or to the billing agent of this physician, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

I authorize this office to furnish my insurance carriers with any information relevant to my claim, and to make direct payment when accepted.

I request that payment of authorized Medigap benefits be made either to me or on my behalf to the provider of service and/or supplier for any services furnished to me by the provider of service and/or supplier. I authorize any holder of Medicare information about me to release to my Medigap carrier any information needed to determine these benefits payable for related services.

Signature_____Date_____

NO SHOW FEE: We require 24 hour notice if you need to cancel or change an appointment. A $25.00 fee will be charged for an office visit if you fail to notify us within the specified time requirement.

PAYMENT POLICY: Your copayment and/or any applicable charges for out-of-pocket visits and procedures are due and payable when you arrive for your appointment. It is an added expense to the practice if we have to bill you. A $15.00 fee will be charged if you fail to make payment in full at your visit.

INSURANCES NOT ACCEPTED: It is patient responsibility to ensure that you are visiting an in-network physician prior to your visits. Our office provides patients with Self-Pay rates for those patients who have insurances not accepted by Dr. Schwartz. Self-Pay payments are due upfront. Health insurance plans NOT accepted: 1199, Emblem Health, Fidelis, GHI, Healthnet, HIP, Hudson Health Plan, Magnacare, Medicaid and all Medicaid managed care plans, Pathway Blue Cross Blue Shield, PHCS, Pomco, Wellcare. It is recommended that you call your specific insurance provider to review your benefits and ensure Dr. Schwartz's participation prior to your visit.

Signature_____Date_____

HIPAA ACKNOWLEDGEMENT

I, _____ acknowledge that I have been provided with a copy of Hara J. Schwartz, MD PLLC's HIPAA Privacy Notice and have been given an opportunity to read and ask questions about the notice.

Signature_____Date_____

History and Intake Form

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Artificial joints
Asthma
Atrial fibrillation
BPH
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Pacemaker
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Valve Replacement
None

Other _____

Past Surgical History: (please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
PTCA
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement within last 2 years
Kidney Biopsy
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP
Skin Biopsy
Basal Cell Cancer Surgery
Squamous Cell Carcinoma Surgery
Melanoma Surgery
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
None

Other _____

Skin Disease History: (please circle all that apply)

Acne	Dry Skin	Poison Ivy
Actinic Keratoses	Eczema	Precancerous Moles
Asthma	Flaking or Itchy Scalp	Psoriasis
Basal Cell Skin Cancer	Hay Fever/Allergies	Squamous Skin Cancer
Blistering Sunburns	Melanoma	None

Other_____

Do you wear Sunscreen? Yes No
If yes, what SPF? _____
Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma? Yes No
If yes, which relative(s)?_____

Cautions: (please circle all that apply)

Have you ever had difficulty stopping bleeding?	Yes	No
Do you require antibiotics prior to a surgical procedure?	Yes	No
Have you had an artificial joint replacement?	Yes	No
If yes, when and what body locations? _____		
Do you have an artificial heart valve?	Yes	No
Do you have a pacemaker?	Yes	No
Do you have a defibrillator?	Yes	No
Are you pregnant or currently trying to get pregnant?	Yes	No

Medications: (Please enter all current medications)

_____
_____
_____

Allergies: (Please enter all allergies)

_____
_____
_____

Social History: (Please circle all that apply)

Currently Smokes	Drug Use
Has smoked in the past	None

Other_____

Review of Systems: Are you currently experiencing any of the following? (Please check yes or no for the following)

Symptom	Yes	No
Abdominal Pain		
Anxiety		
Bleeding Problems		
Bloody Stool		
Bloody Urine		
Blurry Vision		
Changing Mole		
Chest Pain		
Cough		
Depression		
Fever or Chills		
Headaches		
Hay Fever		
Joint Aches		
Muscle Weakness		
Neck Stiffness		
Night Sweats		
Rash		
Seizures		
Shortness of Breath		
Sore Throat		
Thyroid Problems		
Unintentional Weight Loss		
Wheezing		

Other Symptoms:_____