Lake Medical and Chiropractic Center
Mark Schoemann, M.D., F.A.C.S.
DIPLOMATE, AMERICAN BOARD OF PLASTIC SURGERY
FELLOW, THE AMERICAN COLLEGE OF SURGEONS

Confidential information required for our case history file. Please answer each question.

( ) I have reviewed and understand the HIPAA privacy policy. **Initial: _____ (copy available upon request)**

Patient's Name: _____ Age: _____ Birth Date: _____

Address: _____City: _____ State: _____ Zip: _____

Social Security #: _____ Driver License #: _____ Marital Status: S M D W

Home Phone: _____Work Number: _____Cell Phone: _____

Email Address: _____Preferred Contact Method: ( ) Home ( ) Cell ( ) Email ( ) Text

Emergency Contact Name and Phone Numbers: _____
Patient Employed By: _____ Occupation: _____
Business Address: _____
What would you like to achieve with plastic surgery or cosmetic injectables?
_____

What time frame are you considering for procedure? ( ) As soon as possible ( ) 1 – 3 months ( ) 4 – 6 months
( ) 6 – 12 months ( ) Just need information. Are you interested in financing? Yes _____ No _____

Who may we thank for referring you to our office? _____
Do you have medical health insurance? Y ( ) N ( ) Insurance carrier: _____

Do you have a family physician? If so, please state physician's name, address and telephone numbers:
_____
_____
Have you been under the care of any physician for any medical or surgical condition in the last five years? If so, please list physician and condition treated for:
_____
_____
_____
Are you presently under psychological or psychiatric care? If so, please state therapist's name and length of treatment:
_____
Please list all surgery, including cosmetic surgery that you have had including the dates:
_____
_____
_____

Please list medications that you are presently taking, including aspirin or Ibuprofen. Please include dosages, frequency and the reason for taking the medication:
_____
_____

Do you have any known allergies? If so, please list: _____

Are you in good health at the present time? YES_____ NO _____
If answer is no, please explain_____

Do you smoke? If so, how many packs per day? _____
Do you drink alcohol? If so, approximately how much? _____
For Women: Is there a possibility that you are pregnant? _____
When was your last general physical exam? _____

Do you suffer from any of the following?	YES	NO
● Asthma, chronic bronchitis or other lung problems	____	____
● Heart disease, including angina, arrhythmias or prior heart attacks	____	____
● High Blood Pressure	____	____
● Diabetes	____	____
● Kidney disease	____	____
● Hepatitis or other liver diseases	____	____
● Peptic ulcers	____	____
● Ulcerative colitis or other intestinal problems	____	____
● Lupus, scleroderma or other autoimmune diseases	____	____
● Bleeding disorders	____	____
● HIV or other communicable diseases	____	____

● Other significant medical problems? _____

ASSIGNMENT AND AGREEMENT:
I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled including Medicare and other government sponsored programs, private insurance and any other health plans to: Lake Medical Center and Mark B. Schoemann, M.D. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits.

I further agree to pay all charges of Lake Medical Center and Mark B. Schoemann, M.D., not paid by insurance in consideration for medical and/or surgical benefits provided.

If any litigation or arbitration is commenced between the parties hereto or their personal representative concerning any matter relating to this entitled, in addition to any other relief that may be granted, to a reasonable sum for their attorney's fees. The amount of attorney's fees awarded shall be detained by the court or arbitrator in such litigation or in a separate action for that purpose.

_____ _____ _____
Printed Patient Name Signature of Patient Date