Richard W. Swift, M.D., F.A.C.S.
Board Certified Plastic Surgeon
110 E. 87th St. New York, N.Y 10128
(212) 828-9906 Fax (212) 828-9910
www.richardswiftmd.com

All of this information is confidential and protected by the law.

Name:_____ Date of Birth: _____ Age:_____ Sex:___

Soc. Sec. # _____-___-____ Marital Status __Single __Married__ Divorce __ Widow

Home Address_____ City_____ State_____ Zip_____

Home Phone #_____ Cell Phone #_____

Emergency #_____ Relationship:_____

E-mail Address_____

Physician: _____ Office Tel#_____

Employer: _____ Bus. #_____

How did you hear of us? _____ Friend_____ Magazine_____ Online

How do you get information on plastic surgery? _____ TV _____ Online ___ Magazines

What cosmetic procedures are you consulting with Dr. Swift? _____
_____

What is your time frame for surgery? ___ASAP __3Months __6 Months __ Within this year? ____Other

Have you consulted another Doctor about the procedure? Yes___ No___

MEDICAL HISTORY

Weight: _____ Height:_____ Drug Allergies/Sensitivity_____

Do you Smoke? Y/N - How much? _____ Alcohol? Y/N- How much? _____

Do you take: Multivitamins? Y/N Aspirin? Y/N Do you use illegal drugs? Y/N _____

Previous Surgeries (including dates): _____

Previous Illnesses:_____ Date of last physical exam:_____

List ALL medications (including birth control, herbal supplements, vitamins):
_____

Any psychiatric or mental difficulties: _____

OVER ->

If you have had any problems with the following, please circle and describe:

Hair	Breast Pain	Breast Discharge
Ears	Eyelids	Breast Lumps
Vision	Skin, Eyes, Face	Lumps in Armpits
"Dry Eyes"	Teeth	Jaw
Neck	Sore Throat	Lumps in Neck
Breathing	Heart	Bleeding Disorders
Digestion Difficulties	Abdominal Pain	Legs
Arms	Hands	Trunk
Extremities	Diabetes	Other_____

Med Ins:_____ Policy Holder:_____ ID# _____

Address: _____ Group # _____

City: _____ State: ____ Zip: _____ Phone # _____

It is your responsibility to pay any deductible amount, coinsurance or any other balance not paid by you insurance. We request that our charges for office visits are to be paid at the conclusion of each visit. Understand and agree that if this account should become delinquent, past 4 months, you shall be responsible for any collection fees up to 1/2 of the unpaid balance. I assign all medical and/or surgical benefits to include major medical benefits to which I am entitled to Dr. Swift. I understand I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

SIGNATURE _____TODAY'S DATE _____