DELAWARE PLASTIC AND RECONSTRUCTIVE SURGERY
PLEASE PRINT CLEARLY AND ANSWER ALL QUESTIONS

Date _____

Name, First _____ M.I. _____ Last _____ Age _____ Birthdate _____

Address _____ City _____ State _____ Zip_____

Cell # _____ Home # _____ Wk.# _____ SS Number _____

Marital Status: Single ____ Married ____ Widowed ____ Divorced ____ Separated ____ Sex: Male ___ Female ____

Spouse's Name _____ Birthdate _____ SS# _____

(For patients who are minors or students)

Mother's name _____

Address (If different than patient's) _____

_____

Occupation _____

Phone _____

Father's name _____

Address (If different than patient's)

_____

Occupation _____

Phone _____

Patient's/parent's Employment Information

Employer _____

Address _____

_____

Occupation _____

Phone _____

Spouse's Employment Information

Employer _____

Address _____

_____

Occupation _____

Phone _____

Please answer the following, in the event that you cannot be reached at the number given above. Please list a relative or close friend with whom we can leave a message.

Name: _____ Phone: _____ Relationship: _____

Family Physician: _____ Address: _____

Patient referred by: _____

In consideration of medical and/or surgical services rendered, I hereby authorize payment directly to Dr. David E. Schmidt. Jr., of the medical and surgical benefits otherwise payable to me, but not to exceed the charge. I understand that I am responsible to the physician/surgeon for charges not covered by this authorization. I further agree that a copy of this agreement, in its entirety, shall serve in place of the original. I hereby authorize Dr. David E. Schmidt, Jr. to release any and all information pertaining to my medical condition to any insurance company and/or physician that may require said information.

Signed _____ Date _____

Witness _____ Date _____

CONSENT FOR PHOTOGRAPHS

In connection with medical services, which I am receiving from my surgeon Dr. David E. Schmidt, Jr., M.D. of Delaware Plastic and Reconstruction Surgery, I consent that photographs may be taken of myself or parts of my body for the purpose of documentation and record keeping, and that photographs shall become part of my medical record.

I also authorize Dr. Schmidt to provide a copy or copies of my photographs to my insurance carrier for documentation as requested and to referring physicians as part of my referral letter.

Signed _____ Date _____

Witness _____ Date _____