STEVEN G. WALLACH, M.D.

1049 FIFTH AVENUE SUITE 2D • NEW YORK NY 10028
PHONE (212)861-6400 • FAX (212)535-3948

Patient's Name: _____ Sex: _____

Social Security #: _____ Date of Birth: _____ Age: _____ Marital Status: _____

Address: _____
(Street) (Apt) (City) (State) (Zip)

Home Phone: _____ Email: _____ Business Phone: _____

Would you like to receive our monthly newsletters with news and specials? ☐ Yes ☐ No

Personal Physician Name and Address: _____

Employer: _____ Occupation: _____

Employer's Address: _____
(Street) (City) (State) (Zip)

Person Responsible for Bill: _____ Phone: _____ Relationship: _____

Address: _____
(Street) (Apt) (City) (State) (Zip)

Referred By: _____ Address: _____ Phone: _____

Person to be notified in case of emergency, Name: _____ Relationship: _____

Address: _____ Home Phone: _____ Business Phone: _____

Reason for today's visit: _____

If Married,

Spouse: _____ Social Security #: _____ Date of Birth: _____

Employer: _____ Occupation : _____

Employer's Address: _____
(Street) (City) (State) (Zip)

Insurance Information

Insurance Carrier Name & Address: _____

Name of Insured: _____ Relationship: _____ SS#: _____

Identification #: _____ Policy #: _____ Group#: _____

Secondary Insurance Carrier Name & Address: _____

Name of Insured: _____ Relationship: _____ SS#: _____

Identification #: _____ Policy #: _____ Group#: _____

I hereby authorize Steven G. Wallach, M.D. to furnish my insurance company and/or Physician all information which the insurance company may request concerning my present illness or injury. I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare and any other health plans to Steven G. Wallach, M.D. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible to Steven G. Wallach, M.D. for all charges whether or not paid by said insurance. In addition, I have received or reviewed the "Notice of Privacy Practices for Protected Health Information" as required by the Health Insurance Portability & Accountability Act of 1996 and it is also available for review and is posted in the office.

_____ _____
Signature of Patient/Responsible Party Date Signed

Contact us: (212) 861.6400 or email: info@stevenwallachmd.com

Steven G. Wallach, M.D.
Plastic and Reconstructive Surgery
1049 Fifth Ave, Suite 2D
New York, N.Y. 10028

PATIENT HEALTH QUESTIONNAIRE

Name:_____ Age:_____ Marital Status:_____ Date:_____
Height:_____ Weight:_____
General Health is ?_____ Have you had a cold or flu in the past month?_____
Are symptoms still present?_____

HAVE YOU EVER HAD OR BEEN TOLD THAT YOU HAD ANY OF THE FOLLOWING CONDITIONS:

	YES	NO		YES	NO
Heart Trouble/Congestive Heart Failure			Glaucoma or Eye Disorder		
Heart Attack/ Chest Pain			Visual Disturbances		
Endocarditis			Other Eye Problems		
Palpitations or Irregular Pulse			Hepatitis A		
Extra Heart Beats			Hepatitis B or C		
Mitral Valve Prolapse			Jaundice		
Stroke or TIA (Transient Ischemic Attack)			Gallstones or Gallbladder Trouble		
Blood Disease			Cirrhosis of the Liver		
High Blood Pressure			Alcoholism		
Abnormal Electrocardiogram(EKG)			Esophageal Varices		
Rheumatic Fever			Frequent Indigestion		
Shortness of Breath			Ulcers		
Asthma			Gastritis		
Bronchitis			Colitis/Crohn's Disease		
Tuberculosis			Constipation		
Pneumonia			Vomiting Blood		
Smoker's Cough			Tarry or Bloody Bowel Movements		
Emphysema			Hemmorrhoids		
Coughing or Spitting Blood			Thyroid Disease		
Hay Fever or Other Allergies			Diabetes		
Frequent Respiratory Infections			Skin Disorders/Rashes		
Nervous Disorder			Arthritis		
Insomnia			Fracture of Neck or Spine		
Drug Addiction/Habit			Bleeding Tendency or Disorder		
Psychiatric Hospitalization or Care			Blood Infection		
AIDS or HIV Infection			Airway Obstruction (Nasal)		
Herpes/Syphillis/or Gonorrhea			Breast Cysts, Tumors, Abscesses		
Cancer			Nipple Discharge		
Kidney/Bladder Problems			Blood Transfusion		
Seizures/ Seizure Disorder					

PATIENT HEALTH QUESTIONNAIRE

1. Do you have **allergic reactions** to any medication? YES NO If so, to which meds? _____
2. Do you react abnormally to any medication? YES NO If so, to which meds? _____
3. Do you have an **allergic reaction** to contrast material? YES NO
4. Do you have any **family history** of cancer, heart trouble, stroke, diabetes, or kidney problems? YES NO
   If so, which family member(s)?_____
5. Do you have **cocktails** regularly, or consume regular amounts of alcoholic beverages, including beer, wine, or other alcohol? YES NO If so how much?_____
6. Do you **smoke**? YES NO If so how much? _____
7. Do you have a history of **excessive bruising or bleeding** following surgery or minor trauma (including tooth extractions or mouth trauma) ? YES NO
8. Have you, or your blood relatives required blood transfusions following previous surgery or trauma? YES NO
   If so, please specify:_____
9. Are you **pregnant**? YES NO When was your last menstrual period? ____/____/____
   Was it normal? YES NO
10. How many pregnancies? _____ Births:_____ Breast fed? YES NO How Long?_____months
11. Have you ever been on Cortisone or steroid treatment? YES NO If so, when? _____
12. Pleas list **all present medications and dosages**, including Birth Control Pills, Hormones, Vitamins, and Over-the-Counter medications:_____
13. Do you take Diuretics? YES NO If so, what? _____
14. When was your last Physical Exam? ____/____/____ By Whom: Dr._____
15. When was your last Eye Exam? ____/____/____ By Whom: Dr._____
16. When was your last Electrocardiogram(EKG) and where?_____
17. When was your last Chest X-ray and where?_____
18. Please list **ALL** prior hospitalizations and surgical operation , including date and reason:

HOSPITALIZATIONS:

Location	Date	Reasons

Surgical Operations:

Location	Date	Reasons

Drug History: Taken In Last 6 Months:

___ STEROIDS (CORTISONE, ACTH, ETC)
___ ANTIBIOTICS
___ DIABETIC MEDICATION
___ THYROID MEDICATION
___ ARTHRITIS MEDICATION
___ TRANQUILIZERS
___ NARCOTICS
___ BLOOD PRESSURE MEDICATION
___ HEART MEDICATION
___ OTHER:_____

Patient's Signature:_____ Date: ____/____/____

STEVEN G. WALLACH, M.D.

1049 FIFTH AVENUE SUITE 2D • NEW YORK NY 10028

PHONE (212)861-6400 • FAX (212)535-3948

Release Statement

Consent to Use of Images/Videos on an Internet Website in a Medical Case Study or as "Before and After" Example of a Medical Treatment and/or Procedure

I, _____ whose signature appears below, do hereby consent to the use of my images in photographs, videos, illustrations, or other likelihoods, for the purposes of publication and display on the internet website(s), social media sites (i.e. Facebook, Snapchat, Instagram, YouTube) and T.V. of:

Steven Wallach, M.D.
1049 5th Avenue, Suite 2D
New York, NY 10028

Signature_____ Date_____

Address_____

City, State, Zip_____

Signature of Parent or Court-Appointed Guardian_____ Date_____

Steven G. Wallach, MD
Plastic and Reconstructive Surgery
1049 Fifth Ave, Suite 2D
New York, NY 10028

Patient Name: _____ Date: _____

Cosmetic Interest Questionnaire

Please check any which interest you.

□Botox □Fillers □Mole/ Birthmark Removal □Skin Care

□Facelift □Rhinoplasty □Blepharoplasty □Breast Augmentation

□ Breast Lift □Breast Reduction □Breast Implant Revision □Arm Lift □Thigh Lift □Breast Reconstruction □Abdominoplasty □Liposuction □Body Sculpting □Body Lift □Brazilian Butt Lift □Butt Dream Lift

□Buttock Implants

Other: _____

Please answer the following questions on a scale of 1 to 5 by circling the appropriate number.

When viewing my face in the mirror, I believe I look younger, the same as, or older than my true age.

Younger Than		*True Age*		*Older Than*
1	**2**	**3**	**4**	**5**

I am not concerned, somewhat concerned, or very concerned about the appearance of my wrinkles.

Not Concerned		*Somewhat Concerned*		*Very Concerned*
1	**2**	**3**	**4**	**5**

Contact us : (212) 861-6400 ***or email: info@stevenwallachmd.com***

Steven G. Wallach, MD
Plastic and Reconstructive Surgery
1049 Fifth Ave, Suite 2D
New York, N.Y. 10028

PATIENT PHOTOGRAPHIC AUTHORIZATION AND RELEASE

I consent to the taking of photographs by Dr. Steven Wallach or his designee of me or parts of my body in connection with the plastic surgery procedures(s) to be performed by Dr. Steven Wallach. I further consent to the release by Dr. Steven Wallach to the American Society of Plastic Surgeons ("ASPS") or the American Society of Aesthetic Plastic Surgery ("ASAPS") of such photographs.

I understand that such photographs may be published by ASPS, or ASAPS in any print, visual or electronic media, specifically including, but not limited to, medical journals and textbooks, for the purpose of informing the medical profession or the general public about plastic surgery methods.

Neither I, nor any member of my family, will be identified by name in any publication. I understand that in some circumstances the photographs may portray features which shall make my identity recognizable.

I understand that I have the right to revoke this authorization in writing at any time, but if I do so it won't have any effect on any actions taken prior to my revocation. If I do not revoke this authorization, it will expire ten years from the date written below. I understand that I may refuse to sign this authorization and such refusal will have no effect on the medical treatment I receive from Dr. Steven Wallach.

I understand that the information disclosed, or some portion thereof, may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). I further understand that, because ASPS is not receiving the information in the capacity of a health care provider or health plan covered by HIPAA, the information described above may no longer be protected by HIPAA and may be redisclosed by ASPS, or ASAPS.

I release and discharge Dr. Steven Wallach, ASPS, ASAPS, and all parties acting under their license and authority from all rights that I may have in the photographs and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of the photographs.

I grant this consent as a voluntary contribution in the interest of public education and certify that I have read the above Authorization and Release and fully understand its terms.

Patient _____ ***Date*** _____

WITNESS/PHYSICIAN _____

I have read the above Authorization and Release. I am the parent, guardian or conservator of _____, a minor. I am authorized to sign this consent on his/her behalf and I grant this consent as a voluntary contribution in the interest of public education.

Parent/Guardian _____ ***Date*** _____

Contact us: (212) 861.6400 ***or email:info@stevenwallach.com***

Steven G. Wallach, MD
Plastic and Reconstructive Surgery
1049 Fifth Ave, Suite 2D
New York, N.Y. 10028

Introduction to Privacy Practices

Dear Patient,

This is a summary of the way medical information about you may be used and disclosed, and how you can get access to this information. Dr. Wallach and his entire staff will use your medical information as part of rendering patient care. Your medical information may be used for treatment, payment, or health care operations. For example, your medical information may be used by the health care professional treating you, by the office insurance coordinator to process your payment for the services rendered, and by administrative personnel reviewing the quality and appropriateness of the care you receive. Your information may also be disclosed pursuant to applicable federal and state law.

This compliance with the "Notice of Privacy Practices for Protected Health Information" as required by the Health Insurance Portability & Accountability Act of 1996 (HIPAA).

The attached Notice is effective as of April 14, 2003.

_____ _____

Patient name and signature Date

Contact us : (212) 861.6400 ***or email: info@stevenwallachmd.com***