SANCTUARY PLASTIC SURGERY

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PATIENT INFORMATION

DATE: _____ **CHART #:24** _____

NAME: _____ **CELL#** _____
ADDRESS: _____
CITY _____ **STATE** _____ **ZIP CODE** _____

Date of Birth: _____ Age: _____ Sex: M___ F___ Marital Status: _____
Employer: _____ Occupation: _____
Business Phone: _____ **E-Mail** _____
Spouse's Name: _____
Emergency Person: _____ Phone: _____
Physician/Internist: _____ Pharmacy Name & #: _____
List All Previous Surgeries/Hospitalizations: _____
_____
_____

Are you Allergic to any Medications? ____ **If yes, list** _____
List All Medications and Vitamins You Are Taking (Including Oral Contraceptives):
Medications: _____
_____
_____

Have you ever taken Accutane? _____ If so, when did you stop? _____

PERSONAL DATA:
Height _____ Weight _____ #Children _____
Previous Mammogram (date) _____ Result _____
History of Breast Masses _____ Previous Biopsy _____
Family History of Breast Cancer (Who) _____

Check Any of The Following Diseases Which You Have or Have Had:

( ) Excessive Bleeding
( ) Headaches/Migraines
( ) Fainting Spells
( ) Psychiatric Care
( ) Cataracts
( ) Glaucoma
( ) Dry Eye Syndrome
( ) Thyroid Disorder
( ) Liver/Hepatitis/Jaundice
( ) High/Low Blood Pressure
( ) Heart Attack/MI
( ) Angina
( ) Heart Murmur
( ) Mitral Valve Prolapse
( ) Irregular/Fast Heartbeat
( ) Rheumatic Fever
( ) Seizure Disorder/Epilepsy
( ) Stroke
( ) Stomach Problems
( ) Blood Transfusion Reaction
( ) Prostate Problems
( ) Gout/Arthritis
( ) Pancreas Disorders
( ) Gall Bladder
( ) Kidney/Bladder
( ) Tuberculosis
( ) Cancer
( ) Ulcers
( ) Circulatory Problems
( ) Pneumonia
( ) Bronchitis
( ) Emphysema
( ) Asthma
( ) Diabetes
( ) HIV/AIDS
( ) Herpes/Cold Sore

PT. INITIALS _____ MD. INITIALS _____

FAMILY HISTORY: List immediate family members either deceased (with cause of death and age) or living with serious illness:

_____

SOCIAL HISTORY: Please check and answer all the following questions:

YES	NO	
( )	( )	Have you or anyone in your family had a problem with Anesthesia? If yes, please explain:
		_____
( )	( )	Do you have any skin problems? If yes, please describe:
		_____
( )	( )	Do you smoke? If yes, how much per day? _____
( )	( )	Are you a former smoker? If yes, when did you stop?
		_____
( )	( )	Do you drink alcoholic beverages? If yes, how often?
( )	( )	Do you have vision problems? If yes, please explain:
		_____
( )	( )	Do you wear eyeglasses?
( )	( )	Do you wear contact lenses?
( )	( )	Do you wear removable dental appliances/denture?
( )	( )	Any illegal drug use?
( )	( )	Do you wear hearing aids?
( )	( )	Do you have breathing problems? If yes, explain:
		_____
( )	( )	Do you have a cough? If yes, describe: ( )moist ( ) dry
( )	( )	Are you on a special diet? If yes, describe:
		_____
( )	( )	Do you have any disease, condition or problem not listed above that you think the doctor should know. If yes, please explain: _____
		_____
( )	( )	Do you have any reason to believe that you are pregnant?

I have read (or have had read to me) the above medical information listing and I hereby certify that I have disclosed all my medical history to the best of my knowledge that the information I have provided above is correct. I understand that I am financially responsible for all charges related to my procedure.

PT. INITIALS: _____ MD INITIALS: _____

SANCTUARY PLASTIC SURGERY

I would like information on:

- ❑ Liposuction
- ❑ Tummy Tuck
- ❑ Scar Revision
- ❑ Facial Implants (chin)
- ❑ Facelift
- ❑ Browlift
- ❑ Ellevate Suture Suspension
- ❑ Breast Augmentation
- ❑ Breast Revision
- ❑ Breast Lift/Reduction
- ❑ Bodytite
- ❑ Facetite
- ❑ Fat Transfer
- ❑ Rhinoplasty
- ❑ Mommy Make Over
- ❑ Brachioplasty
- ❑ Gynecomastia
- ❑ Gender Affirming Top Surgery
- ❑ Blepharoplasty (Eyelid Surgery)
- ❑ Other _____

May our office contact you by phone or email? (Circle one)
May we leave a message? _____

Please tell us how you heard about our practice:

- ❑ Physician _____
- ❑ Paper/Magazine _____
- ❑ Friend _____
- ❑ Patient _____
- ❑ Website _____
- ❑ Other _____

I understand that to schedule a surgery date, a 20% deposit or $500.00, whichever is greater, must be paid the day that surgery is booked. This deposit is **NON-REFUNDABLE.**

I understand that all surgical fees are non-negotiable.

_____ _____

Patient Signature Date

PT. INITIALS: _____ MD INITIALS: _____

SANCTUARY PLASTIC SURGERY

NOTICE OF INSURANCE

Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. **YOUR DOCTORS HAVE DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE** This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against noninsured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law.

Florida Statute #458.320

Jason Pozner, M.D.

Kenneth Kushner, M.D.

Elliot Jacobs, MD

Patient Signature

Date

ACKNOWLEDGE THAT I HAVE RECEIVED THE ATTACHED PRIVACY NOTICE

I acknowledge that I have received the attached Privacy Notice.

Patient Signature/Personal Representative _____ Date _____

If Personal Representative's signature appears above, please describe Personal Representative's relationship to patient:

_____

INSURANCE COVERAGE:
SANCTUARY PLASTIC SURGERY DOES NOT ACCEPT HEALTH INSURANCE, AUTO INSURANCE OR LETTERS OF PROTECTION. WE DO NOT FILE INSURANCE CLAIMS OR COMPLETE CLAIMS FORMS. ALL FEES ARE PAYABLE WHEN SERVICES ARE RENDERED. WITH REGARD TO SURGERY, ALL FEES ARE TO BE PAID IN FULL 14 DAYS PRIOR TO THE PROCEDURE. NO EXCEPTIONS WILL BE MADE

Patient Signature _____ Date _____

HIPAA RIGHT OF ACCESS FOR FAMILY MEMBER/FRIEND

Due to the HIPAA regulations, I hereby authorize the following names of family members or friends listed below to discuss and participate in my medical care. I understand that if the names are not listed below Sanctuary Plastic Surgery, can not release any information. You may revoke this authorization in writing at any time by notifying your health care providers in writing.

NAME	RELATIONSHIP
_____	_____
_____	_____

☐ Please check this box if you consent to having your Patient Health Information sent to Sanctuary Medical Aesthetic Center if you are referred to them by one of our physicians.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

_____ DECLINE