GARRAMONE PLASTIC SURGERY

(239) 482-1900

Patient Information as of _____ (enter today's date)

(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name _____
First Middle Last

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Other Phone _____

Any restrictions for contacting you? ❒ No ❒ Yes E-mail _____

Contact Restrictions: _____

Age _____ Birthdate _____ SS# _____ Gender ❒ Female ❒ Male

Marital Status ❒ Single ❒ Married to: _____ ❒ Other: _____

Patient's Employer _____ Occupation _____

Work Phone _____ Ext: _____ Is it okay to call you at work? ❒ Yes ❒ No

Address _____
Street & Suite # City State Zip

How did you hear about Garramone Plastic Surgery? (Mark all that apply)

❒ Email ❒ TV Ad ❒ Phone Book ❒ Magazine ❒ Newsletter ❒ Seminar ❒ Salon ❒ Web

❒ Friend/Relative: _____ ❒ Doctor: _____ ❒ Other: _____

If you were referred by a specific person, may we thank them? ❒ Yes ❒ No

Emergency Contact
(Not in your household) _____ Relationship to Patient _____

Home Phone _____ Work Phone _____ Other Phone _____

Primary Health Insurance Company _____

Policy # _____ Group # _____ Ins. Phone _____

Referral Required? ❒ No ❒ Yes Copay? ❒ No ❒ Yes, $ _____

Insured: Name _____ DOB _____ Employer _____

Secondary Health Insurance Company _____

Policy # _____ Group # _____ Ins. Phone _____

Referral Required? ❒ No ❒ Yes Copay? ❒ No ❒ Yes, $ _____

Insured: Name _____ DOB _____ Employer _____

I understand that office visit charges are payable on the day service is rendered. I authorize Garramone Plastic Surgery to bill my insurance company for medically necessary services. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Garramone Plastic Surgery and myself.

Patient Signature _____ **Date** _____

GARRAMONE PLASTIC SURGERY

(239) 482-1900

Health Information as of _____ (enter today's date)
(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name _____
First Middle Last

Age _____ Birthdate _____ Height _____ Weight _____ Gender ❒ Female ❒ Male

Purpose of Visit: _____

_____

Previous Surgeries with Dates: (cosmetic and non-cosmetic)

_____

_____

_____

Past Surgical - Anesthesia History: *mark all that apply. If none apply initial here:*_____

- ❒ Family History of Unexpected Death(s) following General Anesthesia or Exercise
- ❒ Family or Personal History of MH (Malignant Hyperthermia)
- ❒ Muscle or Neuromuscular Disorder
- ❒ High Temperature following Excercise
- ❒ Personal History of Muscle Spasm, Dark or Chocolate Colored Urine
- ❒ Unanticipated Fever Immediately Following Anesthesia or Serious Exercise
- ❒ Personal or Family History of Bleeding Problems

Do you smoke? ❒ No ❒ Yes, How many packs a day? _____ **Do you use Vapor?** ❒ No ❒ Yes

Do you drink alcohol? ❒ No ❒ Yes, How much daily? _____

Medications: (include all Prescriptive, Over-The-Counter, Vitamins and Herbal medications taken regularly)

_____

_____

_____

Drug or Latex Allergies: (please indicate if none)

_____

_____

Primary Physician _____ Phone _____
First and Last Name

Date of Last Physical: _____

The above information is accurate and complete to the best of my knowledge.

Patient Signature _____ **Date** _____

Provider Signature _____ **Date** _____

MEDICAL HISTORY

HAVE YOU HAD OR DO YOU CURRENTLY HAVE?	YES	NO	NOTES	HAVE YOU HAD OR DO YOU CURRENTLY HAVE?	YES	NO	NOTES
Any Bleeding Issues							
Rheumatic Fever				Phlebitis			
Damaged Heart Valve				Thyroid trouble			
Heart Murmur				Diabetes			
High Blood Pressure				Low Blood Sugar			
Low Blood Pressure				Kidney trouble			
Chest Pain, Angina				Dialysis			
Heart Attack				Arthritis			
Irregular Heart Beat				Rheumatoid Arthritis			
Cardiac Pacemaker or Defibrillator				Implants—i.e. dental, joint, breast			
Heart Surgery				Joint pain or aches			
Asthma				HIV or AIDS			
Bronchitis/Chronic Cough				Sexually transmitted disease			
Tuberculosis				Pain Medications			
Emphysema				Do you bruise easily			
Difficulty Breathing				Blood transfusion			
Do you smoke or use tobacco				Fainting spells/Dizziness			
Hay fever, Sinus problems				Dry eye			
Allergies				Contact lenses			
Blood Disorders, Anemia				Eye Disease/Glaucoma			
Infectious Mononucleosis				Mental health problems			
Jaundice/Hepatitis				Chronic fatigue			
Liver Disease				Stomach Ulcers			
Stroke				Chemotherapy			

SKIN HISTORY

When you are exposed to the sun, do you…	☐Tan Only	☐Burn & Tan	☐Burn	
Do you use tanning beds?	☐Yes	☐No		
Have you had skin cancer?	☐Yes	☐No	If so, what type and location:	
Precancers?	☐Yes	☐No		
Atypical Moles?	☐Yes	☐No		
Keloid scars?	☐Yes	☐No		
Eczema?	☐Yes	☐No		
Fever Blister/Cold Sores?	☐Yes	☐No		
Accutane?	☐Yes	☐No	When?	
Do you wear sunblock?	☐Yes	☐No	SPF #:	What Brand?

Specify any other **skin conditions** and/or **medical conditions**:

FAMILY SKIN HISTORY				WOMEN ONLY		
Skin cancer?	☐Yes	☐No	If so, what type:	Are you pregnant or breast feeding?	☐Yes	☐No
Precancers?	☐Yes	☐No		Date of last menstruation?	☐Yes	☐No
Atypical Moles?	☐Yes	☐No		Are you trying to conceive?	☐Yes	☐No
Keloid scars?	☐Yes	☐No		Have you experienced menopause?	☐Yes	☐No
Eczema?	☐Yes	☐No	Other:	If yes, date menopause started:		

Patient Signature _____ **Date** _____

Provider Signature _____ **Date** _____

New Patient Consent to the Use and Disclosure of Health Information
For Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, Garramone Plastic Surgery originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Privacy Policy* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Garramone Plastic Surgery is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Garramone Plastic Surgery reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Garramone Plastic Surgery change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following **restrictions** to the use or disclosure of my health information:

_____

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax or email.

By my signature below I understand that Florida law generally requires that physicians carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. I further understand that Florida law imposes strict penalties against noninsured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. I understand that the physician listed above has elected, pursuant to Florida law, not to carry medical malpractice insurance. I understand that this election is permitted under Florida law, subject to certain conditions, and understand that I have been provided with notice of this election pursuant to Florida law.

PHOTOGRAPHIC CONSENT FORM: I hereby grant Ralph Garramone, MD, PA and Garramone Plastic Surgery permission to take photographs of myself and to publish those photographs for any lawful purpose, including, but not limited to, documentation of the patient's medical record, submission to insurance carrier for prior authorization for surgery. In addition, the photos may be used on their website, social media accounts, and promotional materials, either digital or in print, in perpetuity. I further waive any rights of privacy or compensation associated with the use of my images for the purposes outlined above.

*Initial*_____

PAYMENT POLICY: You are responsible directly to the office for payment of your account regardless of the status of medical or liability insurance claims. The office of Garramone Plastic Surgery will file your claim as a courtesy to you. This office does not accept responsibility for collecting your insurance claims or negotiating settlement on a disputed claim. Services that are performed that are paid with a credit card or debit card or third party financing are not eligible for credit or credit card challenge. I will not challenge credit card payments once the service is provided, as per this agreement. The practice encourages a complete post-op care and follow-up interaction to address any issues that might arise. I, the patient, agree that this non-credit or credit card challenge agreement is irrevocable.

*Initial*_____

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION: I authorize Garramone Plastic Surgery and/or the staff to release information to the following individuals regarding my appointment and account history, and hereby authorize these individuals to reschedule, verify, make cancellations and tender payment on my behalf.

Name: _____ Name: _____

Name: _____ Name: _____

Name: _____ Name: _____

I fully understand and accept the terms of this consent.
I have received and understand the Notice of Privacy Policy.

_____ _____
Patient's Signature Date

Rev. 12/2016

FOR OFFICE USE ONLY
[ ] Consent received by _____ on _____.
[ ] Consent refused by patient, and treatment refused as permitted.
[ ] Consent added to the patient's medical record on _____.