PLASTIC AND RECONSTRUCTIVE SURGERY
COSMETIC AND HAND SURGERY
WELCOME TO OUR OFFICE

PATIENT INFORMATION

Today's Date:_________________

Patient's Name:____
First Middle Last

Address:____ Phone #: ( )_________________
Street City State Zip

e-mail address:____

Gender(circle one) Male Female Birth Date: (required)____________________ Age: __________

SS #:(required)___________________________

Marital Status (circle one): Single Married Separated Divorced Widowed Other

Parent's Names: (Only if patient is a minor) ____

Occupation of Patient **(or Mother if Patient is minor)**:______________________________________

Employer:_____________________________________

Employer's Address:____ Employer's Phone #:____
Street City State Zip

Spouse's Occupation (**or Father if Patient is minor**) :______________________________________

Spouse's Employer:_____________________________________

Employer's Address:____ Employer's Phone #:____
Street City State Zip

Whom may we thank for referring you to our practice?

Friend / Aquaintance /Relative (name)________________________________Doctor (name)_______________________________

Hospital ER_______________________

OR (Circle One): Community News *tbt NOW in Carrollwood Other Publication:________________________________

Whom should we contact in case of emergency? Name:__________________________ Relationship to patient:_______________

Address:____ Phone #:( )________________________

INSURANCE INFORMATION
(Not applicable for cosmetic surgery patients)

Primary Insurance Company:__________________________________ Secondary Insurance Company:_________________________________

ID#_______________________ Group #_______________________ ID#_________________________ Group #_______________________

Subscriber's Name____ Subscriber's Name____

Auto Accident or Worker's Comp Claim #____

PAYMENT IS EXPECTED AT TIME OF SERVICE.

MEDICAL INFORMATION

Do you have **ANY** allergies ? Include any drug, food, plant or animal allergies:____

What is the reason for today's visit?____

Was this condition the result of an accident? Yes No If yes, did it happen at: Work Home Other___________________
Date of injury:_______________________ Are you currently under the care of another physician? Yes No

If yes, who?____

Name of your Primary Care Physician (PCP):_________________________________ Phone #:___________________________

Do you have or have had in the past any of the following diseases/ conditions? Check those that apply, and date of diagnosis:

__________ Aids / HIV
_________ Diabetes
_________ Migraines

___________ Allergies / Hay Fever
___________ Dizziness / Fainting
_________ Nervousness

___________ Anemia
__________Epilepsy
_________ Prostate Disease

__________Arthritis
_________Gall Bladder Disease
_________ Rheumatic Fever

___________ Bleeding Disorders
_________Gout
__________Shortness of Breath

___________Bronchitis
_________Bowel Irregularity
________ Heart Attack

_________ Stroke
_________ Heart Disease
_________ Tuberculosis

__________ Cancer
_________ Heart Murmur
_________ Tumors / list____________

___________ Chest Pain
_________ Heart Palpitations
_________ Ulcers

__________ Chronic Rashes
___________Hepatitis
_________ Chronic Fatigue Syndrome

_________Circulatory Problems
_________ High Blood Pressure

__________ Depression
_________ Kidney Problems
_________Chronic Pain (explain)
____
____

__________Fibromyalgia

________Other________________
____

Family History: (Please list any family diseases / conditions)____
____
____

Have you had any of the following in the past year?

_________Frequent headaches
_________Back ache
_________Blood in stool
_________Blood in urine
_________Shortness of breath
_________Rapid heartbeat (tachycardia)
_________Bruise easily
_________Bleed easily
___________Chest pain
___________Chronic cough
___________Frequent infections
___________Change in mole or skin lesion

Please list all hospitalizations and surgeries, include year:____
____
____

Please list all current medications, including dosage and frequency:____
____

Do you take any of the following? Include dosage and frequency:

Aspirin___________________________
Excedrin___________________________
BC Powder_________________________
Motrin____________________________
Midol_____________________________
Herbalife___________________________
Anacin____________________________
Excedrin Migraine____________________
Goody Powder________________________
Aleve______________________________
Nuprin______________________________
Alka Seltzer__________________
Bufferin_____________________
Advil_________________________
Anaprox_____________________
Metabolife___________________

Do you take any herbal remedies, vitamins, supplements? Include dosage and frequency:
____
____
____

Female Patients:
Number of children:_________ Pregnant? Yes No
Last Menstrual Period / Date:__________________
Hysterectomy: Yes No Date:________________
Tubal Ligation: Yes No Date:________________

COSMETIC PATIENTS ONLY

List any other cosmetic surgical procedures you have had in the past:____
____
____
What surgical procedures would you like to discuss with the doctor?____
____
____

What do you expect the surgery to accomplish?____
____

These statements in the medical history are true to the best of my knowledge and I have not withheld information regarding my health from Dr. Guerriere or his staff.

Date:_____________________________ **Signature:** ____

FINANCIAL RESPONSIBILITY

(NON-COSMETIC PATIENTS ONLY)

I recognize that I am requesting treatment by Cilio N. Guerriere, M.D., and that I am responsible for any costs for that treatment, regardless of whether or not I have insurance coverage. I agree to promptly pay upon receipt, any statement for services rendered. I further agree that if any amount remains outstanding for a period of sixty (60) days, that balance will be considered to be delinquent and may be turned over to a collection agency, or an attorney for collection. If the account is turned over to a collection agency, or an attorney, because the account is delinquent, then and in that, I agree that in addition to the charge made by Dr. Guerriere for medical services, I will also pay the charge made by the collection agency and/or reasonable attorneys' fees and costs incurred collecting the unpaid balance of my account.

I understand that Dr. Guerriere does not participate with HMO's or PPO's, and I am responsible for the outstanding balance after the insurance company (HMO or PPO) has paid.

Date:______________________________ ____

Signature of patient or of parent if patient is minor.

RELEASE OF INFORMATION / ASSIGNMENT OF BENEFITS

(NON-COSMETIC PATIENTS ONLY)

I hereby request and direct my insurance carrier to pay directly to C. N. Guerriere, M.D., the surgical and/or medical benefit otherwise due me under the terms of my policy. Payment of this amount as directed shall be the same as if paid by me. I authorize my physician to release to my insurance carrier the complete medical records in his possession concerning my illness and/or treatment. A photocopy or similar copy of this assignment shall be as valid as if it were the original.

Date:___________________________ ____

Signature of patient or of parent if patient is a minor.

COSMETIC PATIENTS ONLY

I hereby give my consent for consultation and examination by Cilio N.Guerriere, M.D.

______________________________________ ___________________________________

Patient's Signature Date