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PATIENT INFORMATION FORM

PATIENT INFORMATION:

Name: _____

Age: _____ **Birth Date**:_____

Sex: M / F **Marital Status**: S / M / W / D

Driver's License #: _____

Social Security #: _____

Address: _____

City: _____ **State**: _____

Zip Code :_____

Hm #: _____

Wk #: _____

Cell #: _____

Email: _____

Would you like to receive our email newsletter?

YES NO

Occupation: _____

Employer: _____

EMERGENCY CONTACT:

Name: _____

Relationship to patient: _____

Phone: _____

Person Financially Responsible:

Patient _____ Parent: _____ Other: _____

If Parent or Other, please complete the following:

Name: _____

Relationship: _____ SSN #: _____

Address:

_____

Phone #:_____

INSURANCE INFORMATION:

Primary Insurance: _____

Policy #: _____ Group #: _____

Name of Subscriber:

_____

Subscriber Date of Birth:

_____

Relationship to Patient:

_____

Secondary Insurance:

_____

Policy #: _____ Group #: _____

Name of Subscriber:

_____

Relationship to Patient: _____

Subscriber Date of Birth: _____

Social Security #:_____

REASON FOR CONSULTATION:

_____

_____

REFERRED BY:

_____

I hereby authorize payment be made directly to my physician (s) or suppliers for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Patient's Signature:

_____

Parent or Guardian's Signature:

_____

Date: _____

MEDICAL HISTORY FORM

Please answer the following questions to the best of your ability. Your answers are for our records only and will be considered confidential.

Name: _____ Age: _____ Sex: M F
Height: _____ Weight: _____ BMI: _____
Medical problems: _____
_____

Prior operations:
1. _____ Date: _____
2. _____ Date: _____

Name of physician: _____ Phone #: _____
Address of physician: _____

1. Are you in good health? ..... YES / NO
2. Any changes in your health in the past year? ..... YES / NO
3. Have you had rheumatic heart disease? ..... YES / NO
4. Damaged heart valves, artificial valve or heart murmur? ..... YES / NO
5. Heart trouble, heart attack, angina, high blood pressure, stroke, arteriosclerosis? ..... YES / NO
6. Chest pain or shortness of breath with mild exertion? ..... YES / NO
7. Diabetes? ..... YES / NO
8. Lung disease, asthma, bronchitis, emphysema? ..... YES / NO
9. Tuberculosis? ..... YES / NO
10. Fainting spells or seizures? ..... YES / NO
11. Liver disease, hepatitis, jaundice? ..... YES / NO
12. Thyroid problems? ..... YES / NO
13. Stomach ulcer or hyperacidity? ..... YES / NO
14. Seizures, stroke, fainting spells? ..... YES / NO
15. Kidney problems, stones, urinary tract infections? ..... YES / NO
16. HIV/AIDS, blood disorders, anemia, abnormal bleeding, blood transfusions? ..... YES / NO
17. Persistent swollen neck glands? ..... YES / NO
18. Have you ever been treated for a growth of tumor? ..... YES / NO
19. Any history of cancer? ..... YES / NO
20. Do you drink alcohol on a regular basis? ..... YES / NO
21. Do you smoke? ..... YES / NO

If you were a smoker at one time, when did you quit? _____

WOMEN:
1. How many: Pregnancies: _____ Births: _____ C-sections: _____ Miscarriages: _____
2. Are you pregnant or trying to become pregnant? ..... YES / NO
3. Do you have problems associated with your menstrual period? ..... YES / NO
4. Are you nursing? ..... YES / NO
5. Are you taking birth control pills? ..... YES / NO

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ALLERGIES & CURRENT MEDICATIONS

Do you have any allergies? .....YES / NO
If you are allergic, please list Medications that you are allergic to:

Type of Reaction (To)	Medication

Have you ever taken weight reduction (diet) pills? .....YES / NO
Do you take medications for osteoporosis (bisphosphonates) such as Fosamax? .....YES / NO
If so, which ones? _____
Please list any medications that you currently take including vitamins and over the counter medications:

Medication	Dose	Frequency

Are there any other medical issues not covered by this form? .....YES / NO
Do you wish to speak to the doctor privately about anything? .....YES / NO

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient's signature: _____ Date: _____

FOR COMPLETION BY THE DOCTOR

Comments on medical history:

Physician's Signature: _____ Date: _____

AREAS OF INTEREST

Facial Procedures:

- ☐ Blephroplasty (Eyelid Lift)
- ☐ Botox/Juvederm
- ☐ Brow or Forehead Lift
- ☐ Fat Injection
- ☐ Facial Liposuction
- ☐ Face or Neck Lift
- ☐ Otoplasty (Ear Pinning)
- ☐ Skin Resurfacing, Laser, etc.
- ☐ Rhinoplasty
- ☐ Torn Earlobe Repair

Breast Procedures:

- ☐ Breast Augmentation
- ☐ Breast Reconstruction
- ☐ Breast Reduction
- ☐ Mastopexy (Breast Lift)
- ☐ Nipple Reduction/Inversion Correction

Body Procedures:

- ☐ Abdominoplasty (Tummy Tuck)
- ☐ Brachioplasty (Arm Lift)
- ☐ Full Body Lift
- ☐ Liposuction

Oral Surgery:

- ☐ Tooth Extractions
- ☐ Dental Implants
- ☐ Orthognathic/Jaw Surgery
- ☐ TMJ
- ☐ Bone Graft

Orthopedic/Hand Surgery:

- ☐ Carpal Tunnel Syndrome
- ☐ Trigger Finger
- ☐ De Quervain's
- ☐ Dupuytren's
- ☐ Ganglion Cyst
- ☐ Tendon Injury
- ☐ Elbow/Finger/Wrist/Hand Fractures

Other Procedures

- ☐ Skin Care
- ☐ Lesions/Moles
- ☐ Telangectasia (Spider Veins)
- ☐ Laser Hair Removal
- ☐ Leg Veins
- ☐ Rosacea
- ☐ Hair Restoration
- ☐ Ear Piercing

Joe Garri, MD, DMD - Teresa Lozano, MD, DDS - Rafael Alcalde, DDS, PhD
Ramiro Perez, MD - Ricardo Castrellon, MD - Tarik Husain, MD -
Osbel Borges, DMD – Gabriel Salloum, MD

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

I, _____, have reviewed/received a copy of
Patient Name

MOSA Notice of Privacy Practices

_____ _____
Signature of Patient/Guardian Date

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement but was unable to do so as documented below:

Date _____ Initials: _____ Reason: _____

Formulario Para La Confirmacion Por Escrito
De Haber Recibido Aviso De Las Practicas De Privacidad..

Yo, _____, he revisado/recibido una copia del Aviso
Nombre del paciente
De las Practicas de Privacidad de MOSA

_____ _____
Firma Del Paciente Fecha

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement but was unable to do so as documented below:

Date _____ Initials: _____ Reason: _____

PATIENT CONSENT & FINANCIAL AGREEMENT FORM

In connection with the medical services that I am receiving, I hereby authorize the release of my information and medical records, including copies of applicable hospital and medical records to:

A. Any third party payer covering the medical services of the patient
B. Other health care professional and institutions involved in the delivery of health care to the patient
C. The proponent of any legally sufficient subpoena, or in response to a court order
D. Employees and agents of the practice, to the degree necessary to facilitate the provision of healthcare services and payment for such services
E. Pharmacies
F. As otherwise required by law

I further consent that photographs may be taken of me or part of my body, under the following conditions:

A. The photographs may be taken only with consent of my physician and under such conditions and at such time as approved by him/her.
B. The photographs shall be taken by my physician or by a designated person approved by my physician
C. The photographs shall be used for medical records and if in the opinion of my physician, medical research, education or science will benefit from their use, such photographs and information relating to my case may be published and republished, either separately or in connection with each other in the interest of medical education, knowledge, or research; provided, however that it is specifically understood that in any such publications or use I shall not be identified by name and reasonable steps are taken to preserve my identity.
D. The aforementioned photographs may be modified or retouched in any way that my physician, in his or her direction may consider desirable.

Regarding Financial Arrangements:

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must however realize that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
2. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
3. We must emphasize that as medical care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for the assistance in the management of your account.

All Patients Must Sign Below:

Patient's/guardian's signature: _____ Date: _____
Print name of patient or guardian: _____
Witness/Translator: _____

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MALPRACTICE INSURANCE

IMPORTANT NOTICE UNDER FLORIDA STATUTE LAW 458.320
PLEASE READ THIS IMPORTANT DOCUMENT AS THESE ARE YOUR RIGHTS UNDER FLORIDA STATUTE LAW 458.320

Dear Patient:

Under Florida law Statute (458.320 F.S.), physicians are generally required to carry medical malpractice insurance or demonstrate financial responsibility to cover potential claims for medical malpractice. I HAVE DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law under certain conditions. Florida law imposes penalties against non-insured physicians who fail to satisfy adverse judgements arising from claims of medical malpractice. This notice is provided pursuant of Florida law statute (459.320 F.S.).

This document MUST BE SIGNED AND WITNESSED before you initiate or continue under the care of Jose I Garri MD, DMD, Ramiro Perez MD, Ricardo Castrellon MD, Tarik Husain MD, Teresa Lozano MD, Rafael Alcalde DDS, or Osbel Borges DMD.

Thank you,

Jose I Garri MD, DMD, Ramiro Perez MD, Ricardo Castrellon MD, Tarik Husain MD, Raymond Lopez DPM, David Gerth MD, Rafael Alcalde DDS, and Osbel Borges DMD.

Note: No treatment can be provided by Jose I Garri MD, DMD, Ramiro Perez MD, Ricardo Castrellon MD, David GerthMD, Tarik Husain MD or Raymond Lopez DPM, unless this form has been read and signed. This form is provided to protect your rights under Florida Statute 458.320.

I, _____ ,have read this document
[PRINT FULL NAME HERE]
And acknowledge and understand its contents.

Signature_____ , Date_____.

Witness_____ , Date_____ .

Copy received by patient _____.

COPY OF STATUE PROVIDED ON REQUEST OR SIGNS CONCERNING THE FLORIDA STATUTE LAW 458.320 ARE POSTED IN OUR OFFICE