MORAITIS PLASTIC SURGERY

PATIENT INFORMATION

Date:_______ Last Name________________________First Name:___________MI:___SS #:_______________

Sex: M F Age_____ Date of Birth__________________ Marital Status: S M D W SEP

Spouse/Partner's Name:______________________Parents' Names **if Patient is a MINOR**: ______________________

Mailing Address _______________________________________City:________________State:_______Zip:_________

Phone # home: (___)__________________cell: (___)______________________ E-Mail:______________________

Would you like to be added to our monthly email list for updates on specials and procedures we offer? (Circle) Y N

Occupation_____________________Employer Name:___________________________________work#: (___)_______

Notify in Case of Emergency:________________________ Relation:________________ Phone #: (___)_______

Primary Care Doctor:_________________________ Phone #: (___)_________________ Fax #: (___)_______

How were you referred to our practice?____

PERMISSION FOR EVALUATION/TREATMENT

I hereby voluntarily consent to and authorize medical care/diagnostic treatment and /or minor surgical treatment by **ISIDOROS MORAITIS, MD** deemed advisable and necessary in the diagnosis and treatment of my condition. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office. I authorize the use and disclosure of any of my past/current medical records for treatment and healthcare operations.
I hereby authorize said assignee to release to CMS/Insurance Carriers and it agents all information needed to determine these benefits or benefits related to services and to verify external prescription history. I understand that I am responsible for any charges incurred if my account is sent to a collection agency and for any returned checks. I understand that Medicare and/or other Insurance Carriers do not cover all office services/ procedures. I agree to take full responsibility for any unpaid balances and that such payment will be made to the said assignee for services.

Signed:________________________________Print:________________________________Date:________

Office Witness:___________________________Print:_________________________________Date:_______

DESIGNATED RELATIVE (OPTIONAL)

_____**(Initial)** I authorize discussion of my general medical condition and diagnosis (including treatment, payment and health care operations) with:
Name: ____________________________________Relation:________________Phone #: (____)________________
Name: ____________________________________Relation:________________Phone #: (____)________________

PRIVACY NOTICE

_____ **(Initial)** I have been given a copy of ISIDOROS MORAITIS, MD, PA's office *privacy notice* as required by HIPAA that provides a complete description of *personal health information* uses and disclosures. I have been provided an opportunity to review it.

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Date:_________________Patient Name:____

PATIENT HISTORY

Reason for your visit today:________________________________Date of Injury, If Applicable:__________

Please list current medical conditions (Heart problems, diabetes, bleeding disorder, etc):________________

____

____

____

Medications currently taken as needed **or** on a regular basis (including over-the-counter and Herbals):_____

____

____

____

Have you **EVER** had:

- □ Asthma
- □ Liver Disease
- □ Lung Problems
- □ Pain in the Chest
- □ Heart Murmur
- □ Heart Disease
- □ Heart Surgery
- □ High Blood Pressure
- □ Seizure Disorder
- □ Rheumatic Fever
- □ Diabetes/ Insulin Use
- □ Pain in the Arms
- □ Breast Disease
- □ Low Blood Pressure
- □ Dizziness
- □ Kidney Disease
- □ Glaucoma
- □ Bleeding Problems

Are you Allergic to:

- □ Foods______
- □ Shellfish/ Iodine
- □ Aspirin
- □ Sulfa
- □ Penicillin
- □ Other Antibiotics__________
- □ Codeine
- □ Demerol
- □ Any anesthetic________
- □ Novocaine/Lidocaine

Please list **any other allergies** not mentioned above:____

Past Surgical History: (Please list any procedures or surgeries you have had, including cosmetic)

SURGERY	DATE	SURGERY	DATE

Do you smoke? □ Yes □ No If yes, how many cigarettes per day?___________

If you are a former smoker, how many cigarettes per day did you smoke_______________
and when did you quit?_________

Do you use any other tobacco products? □ Yes □ No If yes, how often?_____________________

Is there a chance you could be pregnant now? □ YES □ NO □ Not applicable

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Date:_________________Patient Name:____

CONSENT FOR TAKING AND USE OF PHOTOGRAPHS

I hereby grant authority to ISIDOROS MORAITIS, M.D. and/or his designated representatives to take photographs of me (your child, if you are consenting for a minor) with the understanding that such photographs are for confidential clinical purposes of evaluation and treatment, and that all photographs remain the property of ISIDOROS MORAITIS, M.D. I understand that the photographs are a permanent part of my medical record, and as such may be submitted to my insurance for the specific purpose of obtaining reimbursement for authorized services. I understand that my photos may be released to various governing Boards such as, but not limited to, American Board of Plastic Surgery, for purposes of physician Board Certification maintenance in his specialties with the understanding that any identifiable personal information will not be released with photographs.

Signed:________________________________Print:____________________________Date:_______

Office Witness:__________________________Print:_____________________________Date:_______

FINANCIAL POLICY

FORMS OF PAYMENT ACCEPTED: Cash, checks, Master Card, Visa, Discover and Care Credit. Returned checks are subject to a service charge as applicable by law.

PAYMENT FOR SERVICES (SELF-PAY/NON-INSURED): Payment in full is expected before services are rendered unless prior financial arrangements have been made.

PAST DUE ACCOUNTS: Any balances on your account after 90 days may be referred to a collection agency unless other financial arrangements have been made in advance. Any fees that we pay to secure any past due balances may be added to your account. We realize that emergencies do arise and may affect timely payment of your account. If such extreme cases do occur, please contact us promptly for assistance in the management of your account.

PAYMENT FOR ELECTIVE COSMETIC SURGERY: Payment in full is expected before services are rendered. Our office may require a minimum NON-REFUNDABLE deposit of $250, in order to schedule your surgery. This deposit will be applied to your "surgeon's fee" portion of the cost. Payment in full of the surgeon's fee is required two (2) weeks prior to your scheduled procedure or we reserve the right to cancel or reschedule your surgery.

REFUNDS FOR SKIN CARE SERVICES/PRODUCTS: Refunds will be made on pre-paid services that are not rendered, after regular prices are applied to those services already received. All Obagi (non-prescription) home care products are 100% refundable within 30 days of purchase with receipt. Prescription products purchased at our office are non-refundable, non-returnable.

By signing this form, I fully understand and agree to the terms of the FINANCIAL POLICY.

Signed:________________________________Print:____________________________Date:_______

Office Witness:__________________________Print:_____________________________Date:_______