

# 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) Yes No**

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.

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.

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 #: ( ) \_\_\_\_\_

# MORAITIS PLASTIC SURGERY

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:
- |                                            |                                                |                                             |
|--------------------------------------------|------------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> Asthma            | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Liver Disease     | <input type="checkbox"/> Seizure Disorder      | <input type="checkbox"/> Dizziness          |
| <input type="checkbox"/> Lung Problems     | <input type="checkbox"/> Rheumatic Fever       | <input type="checkbox"/> Kidney Disease     |
| <input type="checkbox"/> Pain in the Chest | <input type="checkbox"/> Diabetes/ Insulin Use | <input type="checkbox"/> Glaucoma           |
| <input type="checkbox"/> Heart Murmur      | <input type="checkbox"/> Pain in the Arms      | <input type="checkbox"/> Bleeding Problems  |
| <input type="checkbox"/> Heart Disease     | <input type="checkbox"/> Breast Disease        |                                             |
| <input type="checkbox"/> Heart Surgery     |                                                |                                             |

- Are you Allergic to:
- |                                            |                                                  |                                               |
|--------------------------------------------|--------------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Foods _____       | <input type="checkbox"/> Penicillin              | <input type="checkbox"/> Demerol              |
| <input type="checkbox"/> Shellfish/ Iodine | <input type="checkbox"/> Other Antibiotics _____ | <input type="checkbox"/> Any anesthetic _____ |
| <input type="checkbox"/> Aspirin           | <input type="checkbox"/> Codeine                 | <input type="checkbox"/> Novocaine/Lidocaine  |
| <input type="checkbox"/> Sulfa             |                                                  |                                               |

Please list **any other allergies** not mentioned above: \_\_\_\_\_

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

<b>SURGERY</b>	<b>DATE</b>	<b>SURGERY</b>	<b>DATE</b>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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 Dr. Moraitis' specialties with the understanding that any identifiable personal information will not be released with photographs.

Signed: \_\_\_\_\_ Print: \_\_\_\_\_ Date: \_\_\_\_\_

Office Witness: \_\_\_\_\_ Print: \_\_\_\_\_ Date: \_\_\_\_\_

## FINANCIAL POLICY

**COSMETIC CONSULTATIONS:** A \$150 non-refundable fee is collected at time of service for cosmetic consultations *related to scar revision and second opinions only*. (If this applies to you, you would have been notified at the time you scheduled your consultation.) This fee can be applied to any procedure performed within 90 days of your consultation. After 90 days, it is applied to your consultation. **All other elective cosmetic procedure consultations are complimentary.**

**FORMS OF PAYMENT ACCEPTED:** Cash, checks, AmEx. 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, implant, facility and anesthesia fees 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 home skin care products (non-prescription) 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: \_\_\_\_\_