PATIENT INFORMATION

Name:_____ **Date of Birth:** _____**Age:**_____

Address:_____

City:_____ **State:**_____ **Zip code:**_____

Home Phone: (____)_____ **Cell phone:** (____)_____

May our office leave a message for patient? ☐**YES** ☐ **NO**

E-mail Address: _____

Alternate address (if applicable): _____

City:_____ State _____ Zip code:_____

***** MUST ANSWER THE FOLLOWING *****

Employer:_____ **Occupation** _____ **Work phone** _____

Marital Status: ☐**SINGLE** ☐**MARRIED** ☐**DIVORCED** ☐**WIDOWED** **Gender** _____

Race: ☐ **WHITE** ☐**HISPANIC** ☐**BLACK or AFRICAN AMERICAN** ☐**ASIAN**
OTHER_____

Ethnicity: ☐ **Hispanic or Latin** **Other** _____

Language: ☐ **English** ☐ **Spanish** **Other:** _____

EMERGENCY CONTACT ***(REQUIRED FOR ALL PATIENTS)***

Name: _____ **Phone:**_____ **Relationship:** _____

Who referred you to our office? _____

Personal Physician _____**Phone** _____

PHARMACY (*REQUIRED FOR ALL PATIENTS- If not provided, one will be chosen near to you)*

Name/address _____**Phone**_____

INSURANCE INFORMATION: Medicare # _____

Secondary insurance/Other insurance: ID/Group # :_____

Photographs "Pre" and "Post" operative photographs are essential in Plastic Surgery both for planning and for analysis of postoperative results. It is the policy of the office that all patients coming in for surgery have photographs taken. These photographs are intended solely for use in the office. They cannot be shown to any prospective patients, nor can they be used in any talks or demonstrations without expressed permission by you. I have read the above and fully understand the implications. I hereby give my consent to allow Rafael Cabrera, M.D. to take intra operative and/or postoperative photographs of me.

SIGNATURE: _____ **DATE:**_____

Release of Information/Medical Records and Assignment of Benefits. I hereby authorize Rafael Cabrera, M.D. to release any information acquired in the course of my examination or treatment to my attorneys, physicians, and/or insurance companies or for quality assurance and peer review. I hereby authorize payment directly to Rafael Cabrera, M.D. for surgical benefits and/or major medical benefits under the terms of my insurance. I understand I am financially responsible for all charges whether or not paid by my insurance and fees for effort to collect these charges. I also understand that of finance charge of 1.5% may accrue on all unpaid balances. I also understand there is no relationship between Rafael Cabrera, M.D., P. A. and any other entity and that I may be billed separately by the provider of the service. I hereby authorize photocopies of this form to be as valid as the original. This statement will remain in effect until revoked by me in writing.

SIGNATURE_____ **DATE**_____

Plastic Surgery Specialists of Boca Raton Aesthetic for Reconstructive Plastic Surgery
Rafael Cabrera, M.D., F.A.C.S

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations.

I, _____, understand that as part of my healthcare, this practice originates and maintains health 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 healthcare 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 that if I need to contact the doctor after hours by sending photos or texts, that this method of communication is using a personal device and it is not encrypted.

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations, and that the organization 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 taken action in reliance thereon.

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

☐ I FULLY ACCEPT the terms of this consent ☐I FULLY DECLINE the terms of this consent.

SIGNATURE: _____ **DATE:**_____

HIPPA ☐ **I ACKNOWLEDGE receipt of notice of health information practices**

☐ **I DECLINE receipt of notice of health information practices.**

I _____ , authorize Plastic Surgery Specialists of Boca Raton to disclose my personal health information with the following family members, close friends, physicians, etc.)

Name _____ **Phone**_____

Name _____ **Phone**_____

FINANCIAL POLICY

By signing this notice, I am aware that the practice of Rafael C. Cabrera, ONLY PARTICIPATES WITH MEDICARE. It is PATIENT RESPONSIBILITY to obtain out of network benefits. As a courtesy, claims will be filed on patient's behalf.

_____

Signature **Date** **Witness**

PLASTIC SURGERY SPECIALISTS OF BOCA RATON

AESTHETIC AND RECONSTRUCTIVE PLASTIC SURGERY

NAME _____ **DATE OF BIRTH** _____ **AGE** _____

REASON FOR MY VISIT

☐COSMETIC CONSULT ☐BOTOX ☐FILLERS ☐EMAX

☐MEDICAL CONSULT ☐EXCISION ☐MOHS REPAIR OTHER _____

PATIENT MEDICAL HISTORY

☐No pertinent past medical history
☐Arthritis
☐Asthma
☐Bleeding after surgery
☐Bleeding disorder
☐Breast cancer
☐Bronchitis
☐Cancer
☐Chest pain/tightness
☐COPD
☐Dementia
☐Diabetes
☐Eczema
☐Emphysema
☐Hearing loss
☐Heart disease
☐Heart murmur
☐Hepatitis
☐High blood pressure
☐Hives
☐Impetigo
☐Kidney stones
☐Malignant hyperthermia

☐ MRSA infection
☐Muscle spasm during surgery
☐Neuromuscular disorder
☐Parotid tumor
☐Prostate cancer
☐Pulmonary fibrosis
☐Pulmonary HTN
☐Pulmonary Problems
☐Reflux
☐Restless Leg Syndrome
☐Shingles
☐Shortness of breath
☐Skin cancer
☐Skin disease
☐Sleep apnea
☐Staph infection
☐Stroke
☐Thyroid disorder
☐Tuberculosis
☐Ulcers
☐Urinary tract infection
☐Uterine cancer
☐X-ray therapy

☐Other _____

PATIENT PAST SURGERIES/HOSPITALIZATIONS (If none, please write none)

Surgery/Hospitalization	Date	Anesthesia complication	Notes

FAMILY MEDICAL HISTORY

No contributing family history		Details
Adopted		
Abnormal bleeding		
Abnormal clotting		
Anesthesia problems		
Autoimmune Disorders		
Brain tumor		
Breathing problems		
Cleft lip		
Cleft palate		
Diabetes		
Drug allergies		
Endocrine disease		
Hearing loss		
Heart disease		
Hemophilia		
High blood pressure		
Kidney disease		
Liver disease		
Lung cancer		
Malignant hyperthermia		
Melanoma		
Other cancer		
Ovarian cancer		
Prostate cancer		
Skin cancer		
Substance abuse		
Von Willebrand		
Other		

ALLERGIES (If none, please write none)

Allergy	Reaction	Notes

CURRENT MEDICATIONS (if none, please write none)

Medication	Dosage	Prescribed by

PATIENT SOCIAL HISTORY

ALCOHOL
☐Denies alcohol use
☐Admits alcohol use socially
☐Admits alcohol use daily
☐Admits history of alcoholism

ILLEGAL DRUGS
☐Denies using illegal drugs
☐Admits using illegal drugs
☐Admits to history of drug abuse

HIGH RISK FACTORS
☐Denies high risk factors
☐Admits high risk factors

STD
☐Denies STD history
☐ Admits STD history

PATIENT TOBACCO USE

☐Never Smoked ☐ Former ☐Current tobacco smoker ☐Current smokeless tobacco user

PATIENT SMOKING HISTORY

PACKS PER DAY	LENGTH	QUIT
☐ < 1 pack per day	☐ for < 5 years	☐ quit < 1 year ago
☐ 1 pack per day	☐ for 5-10 years	☐ quit 1-5 years ago
☐ 2 packs per day	☐ for 10-15 years	☐ quit 5-10 years ago
☐ 3 packs per day	☐ for 15-20 years	☐ quit 10-15 years ago
☐ 4 packs per day	☐ for 20-25 years	☐ quit 15-20 years ago
☐ >4 packs per day	☐ for > 25 years	☐ quit > 20 years ago

Have you had a FLU vaccine this year? **YES ___ NO ___**

Have you had PNEUMOCOCCAL PNUEMONIA vaccine? **YES ___ NO ___**

Have you had COVID-19 vaccine? **YES ___ NO ___**

Have you had a colonoscopy with the last 9 years? **YES___ NO____**

Total colectomy_____

Have you had a mammogram within the last 2 years? **YES___ NO____**

Double mastectomy _____

HEIGHT/WEIGHT/BLOOD PRESSURE

Height: ___ ft ____ in

Weight: _____ lbs

MEDICAL HISTORY VERIFICATION

I confirm that I have not withheld any information and all the above information I have provided is accurate and complete to the best of my knowledge. **Patient Initial** _____ **Date**_____