Member of the American Society of Plastic Surgeons

Issa F. Baroudi MD PA

3222 Tamiami Trail
Port Charlotte, FL 33952
Voice: (941) 627-5155
www.baroudimd.com

CIRCLE WHERE APPLICABLE. YOU MAY CIRCLE MORE THAN ONE

*****PRINT LEGIBLY*****

Patient Name: ____
First Middle Initial Last

Nickname: ____

Date of Birth: ____________________ **Social Security Number:** __________________________

Gender: Male Female

Marital Status: Single Married Divorced Legally Separated Widowed

Address: ____
Street Apt. #

____
City State Zip

Home Phone: ( ) ______________________

Work Phone: ( ) ______________________

Cell Phone: ( ) ______________________

Email Address: ____

How did you hear about us? Physician Referral _________________________ Previous Patient

Newspaper Yellow Pages Our Website/Internet Our Facility/Electronic Sign

Friend Referral ___________________________ Other _________________________

Place of Employment: ____

Emergency Contact: ____

Relationship: _____________________________ **Phone:** ( ) _____________________

Signature: ____ Date: ___________________

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MEMBER
THE AMERICAN SOCIETY FOR AESTHETIC PLASTIC SURGERY
The Mark of Distinction In Cosmetic Plastic Surgery®

Circle your choices

PLEASE FILL OUT COMPLETELY

Patient Name: ______________________________

What is your current height? ______________ What is your current weight? ______________

Are you pregnant? (If applicable) Yes No

Immediate Family History (father, mother, brother, sister)

High Blood Pressure Breast Cancer Prostate Cancer Diabetes

Skin Cancer Heart Disease Stroke Other______________

Social History

Do you consume alcohol? No Yes How often? ________

Do you smoke? No Yes Number of packs per day ______

Have you ever smoked? No Yes If yes, when did you quit? ______________

Medical History

Heart Attack Mitral Valve Prolapse Pacemaker Stroke Heart Conditions

Lung Asthma Liver Hepatitis High Blood Pressure Kidney Thyroid

Diabetes Blood Clots Anemia Seizures Cancer Radiation Chemotherapy

Have you ever had a serious infection? Yes No

Please explain in detail any conditions checked above or any conditions that are currently under treatment by another physician:

____

____

Allergies

Are you allergic to any medications or foods? ______________________________

Surgical History

List all operations you have had: ______________________________

____

____

Have you ever had difficulties with Local Anesthesia? __________ General Anesthesia? __________

Signature: ______________________________ Date: __________

MEDICATION LIST

PATIENT NAME: ________________________________

Medication (Including Prescription, Over-the-Counter, Vitamins, Herbal Supplements)	Dosage	How often?	How taken (oral, topical, etc.)

Signature:____Date:________________

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PATIENT CONSENT FORM

Patient Payment Responsibility

I understand I am responsible for payment of services and/or procedures rendered by Issa F. Baroudi, M.D., P.A and Promenades Surgery Center LLC I understand all balances deemed my responsibility by my insurance carrier for services and/or procedures provided by Issa F. Baroudi, MD PA at Promenades Surgery Center LLC will be invoiced to me and payable to the provider of service within (30) thirty days of receipt. In the event it is deemed medically necessary for me to be transferred to an area hospital, I understand I will be responsible for all services incurred with this transfer. Patient responsibilities can include all applicable co-payments, deductibles, and co-insurance amounts. In the event my insurance carrier sends payment of services directly to me, I understand I must forward this payment onto the provider of service. All procedures and/or services deemed not medically necessary or are not covered by my insurance carrier are my responsibility. I understand it is my responsibility to know the terms of my insurance contract. It is my responsibility to notify Issa F. Baroudi, MD PA and Promenades Surgery Center LLC of any changes on my account which include insurance information, change of address, change of phone number or name change.

Medicare Assignment

I have been informed Issa F. Baroudi, MD PA and Promenades Surgery Center, LLC participate and accept Medicare Assignment.

Payment Policies and Assignment of Benefits

A statement for unpaid balances will be sent to me on a monthly basis. It is my responsibility to ensure full payment within 30 days of receipt. I understand if my balance remains unpaid after (90) ninety days, the provider of service will post my account as a collection account. I understand all accounts having a “collection status” will be settled in a court of law. I understand I will be responsible for any and all attorney and court fees. Payments can be made by Credit Card, Check, Cash, or Money Order. If paying by check and it is returned by my bank for any reason, I understand I will receive a separate invoice for the Return Check Fee as well as the amount of the check. This amount must be paid within (7) Seven Business days by Money Order, Cash, or Credit Card. All returned checks not paid will be forwarded to the Florida District Attorney’s office. I have been informed Issa F. Baroudi, MD PA and Promenades Surgery Center LLC operate as separate entities. I understand I may receive a separate statement from a laboratory if testing is required and also for anesthesia if required. I hereby assign my insurance benefits to be paid directly to the provider of service.

Release of Medical Information

I understand Issa F. Baroudi, MD PA and Promenades Surgery Center LLC are permitted to make uses and disclosures of my health information for the purposes of treatment, payment, such as contacting credit card companies should any dispute over charges arise, and health care operations. Protected health information is the information created and obtained in providing the services to me. Such information may include documenting my symptoms, test results, surgical procedures, diagnoses, and complications. It also includes billing documents for those services.

I hereby authorize the provider of service to disclose my health information as outlined in the Notice of Privacy Practices. This form is provided to me to comply with Federal Privacy Law (HIPPA) the Health Insurance Portability and Accountability Act of 1996. The Practice has a Notice of Privacy Practices and I understand I have the opportunity to review it.

Consent to Taking of Photographs

I hereby consent and agree: Photographs may be taken of me or parts of my body with the consent of Issa F. Baroudi, MD PA and under such conditions and at such times as may be approved by Issa F. Baroudi MD PA.

I release and discharge Issa F. Baroudi, MD PA and Promenades Surgery Center LLC, and all parties acting under their license and authority, from any and all claims or actions that I have or may have relating to, my pictures being taken.

Signature: ____ Date: ______________________