Jeff DeMercurio, M.D.
Florida Center for Plastic and Cosmetic Surgery

1425 Hand Ave Suite C
Ormond Beach, FL 32174

Today's Date: _____

Name: _____ _____ _____
First MI Last

□ Male □ Female □ Single □ Married □ Divorced □ Widowed □ Separated

Birthdate: _____/_____/_____ Age: _____ Social Security # _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____Email: _____

Occupation: _____ Employer: _____

Primary Care Physician: _____ Date of last exam: _____

Explain reason for today's office visit :_____

_____

Preferred Pharmacy (include address): _____

How did you hear about us? Facebook_____ **Instagram** _____ **Hometown News** _____ **Google**_____ **Website** _____

Patient Referral (name): _____ **Other:** _____

Emergency Contact/HIPPA Contacts:

Name: _____Relationship: _____ Telephone #: _____

Name: _____Relationship: _____ Telephone #: _____

HIPAA-Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge the receipt of Florida Center for Plastic and Cosmetic Surgery's Notice of Privacy Practices or acknowledgement that a copy of this notice is in our lobby for your convenience (or we can provide one for you). The Notice describes how my health information may be used or disclosed. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the notice by calling 386-317-0444

Adult Patient/Guarantor: _____Date: _____

Print Patient Name: _____

NAME: _____ **Date of Birth**_____

MEDICAL HISTORY SHEET

Current Height: _____ **Current Weight**: _____

HEAD:			**MOUTH:**			**RESPIRATORY:**		
Headaches	Y	N	Fever Blisters	Y	N	TB	Y	N
Seizures	Y	N	Bleeding Gums	Y	N	Short of Breath	Y	N
Dizziness	Y	N	Dentures	Y	N	Cough	Y	N
Fainting Spells	Y	N	Cancer	Y	N	Wheezing	Y	N
Stroke	Y	N				Asthma	Y	N
SKIN:			**BREASTS:**			**CARDIOVASCULAR:**		
Cancer	Y	N	Cancer	Y	N	Pacemaker	Y	N
MRSA	Y	N	Mastectomy	Y	N	High Blood Pressure	Y	N
Rosacea	Y	N	Lumpectomy	Y	N	Rheumatic Fever	Y	N
Acne	Y	N	Fibroids	Y	N	Edema (Swelling legs/arms)	Y	N
						Heart Murmur	Y	N
LYMPHNODES:			**GASTROINTESTINAL:**			Pericardial Pain (Chest Pain)	Y	N
Enlarged	Y	N	Gallbladder	Y	N	Hypotension (Low pressure)	Y	N
Kidney Problems	Y	N	Nausea	Y	N	Phlebitis (inflamed veins)	Y	N
Malignant Hyperthermia	Y	N	Blood in Stool	Y	N	Heart Disease	Y	N
			Ulcer	Y	N	AFIB	Y	N
			Vomiting	Y	N			

IF YOU HAVE ANSWERED "YES" TO ANY OF THE ABOVE, PLEASE EXPLAIN:_____

_____

ANY ADDITIONAL CONDITIONS NOT LISTED: _____

Are you diabetic? YES NO Type? _____ **If yes, who is your Endocrinologist:** _____

Are you under the care of a Cardiologist? YES NO If yes, who is your Cardiologist: _____

Do you take blood thinners? YES NO If yes, please list Medication and reason for taking:

_____

Have you ever been diagnosed with an Infectious Disease such as HIV, Hepatitis, Syphilis, Tuberculosis? YES NO

Are you currently or have you been treated for any Emotional or Psychological Problems in the past? YES NO

If yes, please briefly explain _____

Have you ever had any bleeding problems? YES NO

Have you ever had any blood transfusions or blood products? YES NO

If yes, please explain _____

_____

Have you ever had General Anesthesia? YES NO If "yes", did you have a bad reaction? _____

_____

NAME:_____ **Date of Birth**_____

PERSONAL SURGICAL HISTORY:

SURGERY (ALSO COSMETIC)	HOSPITAL	DATE	ANESTHESIA COMPLICATIONS	SURGEON

Family History (which family member):

BRCA Positive _____ Hemophilia _____ Obesity _____
Breast Cancer _____ High Blood Pressure _____ Other Cancer _____
Diabetes _____ Non-Relevant Family History _____ Other Relevant Family History_____
Heart Disease _____ _____

Social History:

Do you smoke? Y N If so, how many daily? _____ Quit date, if applicable: _____
Drink Alcohol? Y N How often? _____
Do you take aspirin, BC powders, Goody powders, Advil, Motrin, or any other over-the counter pain medications **YES/NO** If yes, please list: _____
Do you use drugs socially or have a history of drug abuse? **YES/NO** If yes, please explain: _____
_____
Are you under the care of a physician for pain management? **YES/NO** If yes, please list physician and contact information: _____

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: (Include all Prescriptions & OTC Medications/Vitamins)

NAME	DOSE	FREQUENCY	NAME	DOSE	FREQUENCY

LIST ANY DRUG ALLERGIES or SENSITIVITIES:

_____ _____
_____ _____

Are you allergic to local anesthesia? YES/NO If yes, please explain: _____
_____

Are you allergic to LATEX or band aids? YES/NO If, yes, please explain: _____

WOMEN PATIENTS ONLY:

Are you pregnant or suspect you may be pregnant or nursing currently? YES NO

Number of pregnancies _____ Number of children _____ Did you breast feed? YES NO

Have you ever had a mammogram? Y N If yes, was it normal? Y N If "no", please explain: _____
_____

NAME:_____ **Date of Birth**_____

FINANCIAL POLICY:

Florida Center for Plastic and Cosmetic Surgery's financial policy requires our office to collect payment for your office visit at the time services are rendered. We accept cash, cashier's check, money order, debit card, Apple Pay, all forms of credit cards, and Cherry.

Patient Consent for Use of Credit cards, Debit Card, and Financing

It may become necessary to release your protected health information to financial parties, credit card entities, banks, and financing companies, when requested, to facilitate your payment. Services that are performed that are paid with a credit card, debit card, or financing third-party are not eligible for payment challenges after services are provided. By signing this form, I am irrevocably consenting to allow Florida Center for Plastic and Cosmetic Surgery, LLC to use and disclose my protected health information to any Credit Card Entity, Bank, or Financing company when they request such information to process an account and assist with payment.

I will not challenge such credit, debit, or financing card payments once the services are provided. The practice encourages complete post-op care and follow-up interaction to address any issues that might arise, which are further addressed in the Revision Policy. I agree that this noncredit card challenge agreement is irrevocable.

Cancellation: As a courtesy to our patients, we may have a waiting list for appointment availability. As a policy, we ask that you contact our office at least 48 hours prior to your scheduled appointment if you need to cancel or reschedule so that we may offer the appointment to another patient. As we understand that things come upon our lives at this time, we do not at this time charge for no-shows and/or last-minute cancellations we wish to not execute for the future. We appreciate our patients and would like to thank you for your consideration of our policies.

Adult Patient/Guarantor: _____**Date:** _____

NAME:_____ **Date of Birth**_____

FOR COSMETIC/SELF-PAY PATIENTS ONLY:

Cosmetic consultations are $75.00.

Surgery Center and/or office surgical suite:

In the interest of safe surgery, laboratory, pathology, and diagnostic tests (up to date mammogram, chest x-ray and/or EKG) may be ordered and are the financial responsibility of the patients as well as the surgeon's fee, anesthesia, and facility fees for the procedure(s) as agreed upon. Medications are not provided by Florida Center for Plastic and Cosmetic Surgery. Medications will be sent to your preferred pharmacy. The fee quoted to you is an estimate and is based on the standard time needed to perform the procedure(s) properly. If the operation room time is extended for medical reasons, additional fees may be billed by the facility and anesthesiologist. Excess operating room time is the exception and not the rule. If there are any additional procedures needed, there will be additional fees. The fees are non-refundable, and you are financially responsible for payment of the additional fees.

Treatment and Complications: The practice of medicine and surgery is not an exact science. Although good results are anticipated, there can be no guarantee or warranty, expressed or implied, by anyone as to your results. Surgical revisions and/or other medical treatment or management of problems and/or complications may be required. These will result in additional charges for which you are responsible. When necessary, most revision surgery is not performed sooner than six months to one year ***after*** surgery. This allows time for all swelling to resolve and healing to be completed.

I have read and understand the above Financial Policy. I agree to be bound by the terms of this Policy. I further agree that, if I default on any obligations under this Policy, I will be responsible for attorney fees, court costs, pre-judgment interest allowed by law, and expenses of collection.

Adult Patient/Guarantor: _____ **Date:** _____

NAME:_____ **Date of Birth**_____

FOR INSURANCE PATIENTS ONLY:

It is the policy of this office to collect the patient's deductible and out of pocket expenses 2 weeks prior to surgery if they have not been met for the calendar year before surgical procedures are performed. For procedures covered by your insurance, we will submit a claim to your insurance company. While we are pleased to be able to provide this service, it is extremely difficult for us to keep track of all the individual requirements of the plans. Each plan has different policies regarding how often services may be rendered and, even more importantly, where those services may be performed. We ask you to inform us if your coverage has any special requirements, such as lab work or hospitalization, that are not covered, we or the selected medical facility will have no choice but to bill you directly for those charges. We have found that many insurance plans provide payment at levels significantly lower than our fees. We take great care in setting our charges well within the acceptable norms for similar services in this area. Insurance companies no longer abide by these norms, rather they establish their own reimbursement schedules. It is our desire that you receive the maximum benefit possible from your health insurance ln order to achieve this we need your assistance in providing us complete and accurate personal and insurance information on the attached form.

Insurance Authorization and Assignment: I hereby authorize Jeffrey DeMercurio M.D., LLC to release the information requested by my insurance company. I also authorize Jeffrey DeMercurio, M.D., LLC to release information to any hospital or physician to which I may be referred by this office. In addition, I authorize Jeffrey DeMercurio, M.D., LLC to request and obtain my medical records from my insurance company, hospitals, and/or physicians who have treated me. I hereby authorize assignment and payment directly to Jeffrey DeMercurio, M.D., LLC from major medical benefits or legal settlements and/or judgments due me. I hereby agrees to pay all charges that exceed or that are not covered by insurance. I understand I will be responsible for any fees attached to this account to recover any uncollected balances.

Adult Patient/Guarantor: _____**Date:** _____

Medicare ONLY PATIENTS: I authorize any holder or medical information about me to release to the Social Security Administration or its intermediaries or carries any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to Jeffrey DeMercurio, M.D., LLC for services rendered to me by its physician(s).

Adult Patient/Guarantor: _____**Date:** _____