DIACO INSTITUTE of PLASTIC SURGERY
TAMPA, FLORIDA

DATE: _____

PATIENT REGISTRATION FORM

Please print the patient information below:

PATIENT INFORMATION

FIRST NAME		HOME PHONE:
MIDDLE NAME:		CELL PHONE:
LAST NAME:		DATE OF BIRTH:
ADDRESS:		SOCIAL SECURITY #:
CITY:	STATE:	O SINGLE O MARRIED O DIVORCED O WIDOWED
ZIP:		O MALE O FEMALE
EMAIL:		REFERRED BY:

EMPLOYMENT

EMPLOYED: O Yes O No	EMPLOYER:
OCCUPATION:	WORK PHONE:

SPOUSE

SPOUSE:	
EMPLOYER:	
OCCUPATION:	WORK PHONE:

EMERGENCY

EMERGENCY CONTACT:	
RELATION TO PATIENT: O SPOUSE O PARENT O FRIEND O OTHER:	
HOME PHONE:	CELL PHONE:

PHARMACY

PHARMACY NAME:	PHARMACY #:

Have you consulted with any other surgeons regarding the surgery(s) you are interested in? O Yes O No

If yes, with whom? _____

PLEASE TURN PAGE OVER ➡

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PATIENT MEDICAL HISTORY FORM

REASON FOR CONSULTATION			
O Breast Augmentation	O Face Lift	O Botox	O Tummy Tuck
O Breast Lift	O Laser Resurfacing	O Fraxel	O Mens Procedures
O Breast Reconstruction	O Eyelids	O Contour Threads	O Skin Care
O Implant Exchange	O Forehead/Brow Lift	O Thermage	O Other
O Capsular Contracture	O Rhinoplasty	O Liposuction	

MEDICAL HISTORY

Do you have any ***ALLERGIES***? O Yes O No		
If yes, please list, (including food and drug):		
Do you have any current ***MEDICAL PROBLEMS***? O Yes O No		
If yes, please list:		
Are you currently taking any ***MEDICATIONS***? O Yes O No		
If yes, please list here:		
Is there a history of ***MEDICAL PROBLEMS*** in your family? O Yes O No		
If yes, please list family member(s) & problems(s) (Example: cancer, diabetes, heart disease)		
Have you ever been ***HOSPITALIZED***? O Yes O No		
If yes, please list date and reason:		
Have you ever had an ***OPERATION***? O Yes O No		
If yes, please list and include dates:		
Have you ever had a ***SERIOUS ACCIDENT***? O Yes O No		
If yes, please list and include dates:		
If parent(s) are deceased, please list age and cause of death:	Mother:	Father:

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PATIENT MEDICAL HISTORY FORM

MEDICAL HISTORY CONTINUED

Do you ***smoke***? O Yes O No	If yes, how many per day?	For how many years?
Do you drink ***coffee/tea/both*** O Yes O No	If yes: How often per day/week?	
Do you drink ***soda***? O Yes O No	If yes: How often per day/week?	
Do you drink ***alcohol***? O Yes O No	If yes: How often per day/week?	
Do you eat ***chocolate***? O Yes O No	If yes: How often per day/week?	
Do you use ***marijuana***? O Yes O No	If yes: How often?	
Do you use ***cocaine***? O Yes O No	If yes: How often?	
Are you ***pregnant***? O Yes O No		
Number of pregnancies:	Number of deliveries:	Number of abortions/miscarriages:
Date of last menstrual cycle:		
Date of your last mammogram:		
Do you take Estrogen or birth control pills? O Yes O No	If yes, please list the brand:	
Do you have a living will? O Yes O No		

PATIENT NOTICE OF PRIVACY PRACTICES:

The entire Privacy Policy Notices of Dr. Diaco are posted in the waiting room for your review. By signing this form, you acknowledge that you have read the HIPPA notice provided.

In conjunction with these privacy practices you will need to provide us with the following information:

1. Name of person(s) and phone number that we may speak to regarding your health. (i.e. spouse, child, etc)

   _____

2. May we leave a message regarding your health or an upcoming appointment on your answering machine?

   O Yes O No

_____ _____ _____

Signature of Patient or Legal Guardian | Print Patient's Name or Legal Guardian | Relationship to Patient

Witness Signature: _____ Date: _____/_____/_____

I have read all the questions on the Patient Registration Form as well as the Patient Medical History Forms and have answered them to the best of my knowledge.

Signature: _____ Date: _____/_____/_____

PLEASE TURN PAGE OVER ➡

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PATIENT INSURANCE FORM

INSURANCE INFORMATION

Even if you are not having surgery through insurance, we prefer to keep your insurance information on file in case you become our patient and your insurance is needed. If you do or do not have insurance, the bottom paragraph is consent for treatment and must be signed.

Do you have medical insurance? O Yes O No		
Primary Insurance Carrier:		
Address:		
City:	State:	Zip:
Phone:		
Insured's Name:	Group #:	
Relationship of patient to insured:	Medicare #:	

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services. I hereby authorize the doctor to administer any treatment, as he may deem advisable in the diagnosis and treatment of the patient. I also authorize any physician, hospital, or clinic to provide full details of my medical history and treatment in this office, and I agree that photocopies of this form will be valid as the original. I hereby authorize payment to the provider of care. I understand that I am financially responsible for all charges not covered by this agreement (including my annual deductible and/or co-payment) at this time of service. I also agree to pay any additional charges for collection fees if I fail to promptly pay for services.

Signature: _____ Date: _____/_____/_____

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SMOKING DISCLOSURE FORM

PATIENT SMOKING DISCLOSURE FORM

All patients must complete a Patient Smoking Disclosure Form

Do you SMOKE? O Yes O No
If yes, how many per day?
For how many years?

When having surgery, you must **QUIT SMOKING** two weeks before surgery and continue to refrain from smoking two weeks after surgery. Smoking can cause skin loss, infection, poor wound healing, and permanent irreversible deformity. The patient understands the above and will comply.

Signature: _____ Date: _____/_____/_____

Print Name: _____