



DIACO INSTITUTE
of PLASTIC SURGERY
TAMPA, FLORIDA

REASON FOR CONSULTATION

Name _____

- ☐ Breasts
- ☐ Eyes
- ☐ Forehead
- ☐ Face
- ☐ Nose
- ☐ Chin
- ☐ Lips
- ☐ Wrinkles
- ☐ Tummy
- ☐ Arms
- ☐ Legs
- ☐ Ears
- ☐ Body
- ☐ Juvederm
- ☐ Botox
- ☐ FRAXEL
- ☐ Mole/Cyst Removal
- ☐ Men's Procedures
- ☐ Aesthetic Services
- ☐ Skin Care Products
- ☐ Other _____

- ☐ If you wish to be added to our mailing list for monthly specials please provide your email address.



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:	<input type="radio"/> SINGLE <input type="radio"/> MARRIED <input type="radio"/> DIVORCED <input type="radio"/> WIDOWED
ZIP:		<input type="radio"/> MALE <input type="radio"/> FEMALE
EMAIL:		REFERRED BY:

EMPLOYMENT

EMPLOYED: <input type="radio"/> Yes <input type="radio"/> No	EMPLOYER:
OCCUPATION:	WORK PHONE:

SPOUSE

SPOUSE:	
EMPLOYER:	
OCCUPATION:	WORK PHONE:

EMERGENCY

EMERGENCY CONTACT:	
RELATION TO PATIENT: <input type="radio"/> SPOUSE <input type="radio"/> PARENT <input type="radio"/> FRIEND <input type="radio"/> OTHER:	
HOME PHONE:	CELL PHONE:

PHARMACY

PHARMACY NAME:	PHARMACY #:
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Have you consulted with any other surgeons regarding the surgery(s) you are interested in? ☐ Yes ☐ No

If yes, with whom? _____

PLEASE TURN PAGE OVER ➡

NOTICE TO ALL PATIENTS:

PLEASE NOTIFY THE DOCTOR IF YOU ARE TAKING ANY **ANTI-DEPRESSANTS**. THIS MAY REQUIRE ADDITIONAL LAB WORK PRIOR TO SURGERY. UNDERSTAND THAT SURGERY MAY BE RESCHEDULED DUE TO ABNORMAL LAB RESULTS.

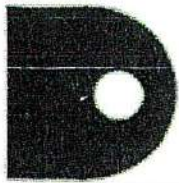
Are you currently taking any anti-depressants?	YES	NO
If YES, please list medication(s):		

I have reviewed the material above and have answered the question(s) to the best of my knowledge. I acknowledge that this type of medication may require additional lab work prior to surgery. I understand that my surgery may be rescheduled if the lab results are abnormal. I understand that it is my responsibility to disclose to the doctor any and all medications that I am currently taking prior to surgery.

Print Name _____

Signature _____ **Date:** _____

MEDICAL HISTORY



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PATIENT MEDICAL HISTORY FORM

MEDICAL HISTORY CONTINUED

Do you smoke ?	<input type="radio"/> Yes <input type="radio"/> No	If yes, how many per day?	For how many years?
Do you drink coffee/tea/both	<input type="radio"/> Yes <input type="radio"/> No	If yes: How often per day/week?	
Do you drink soda ?	<input type="radio"/> Yes <input type="radio"/> No	If yes: How often per day/week?	
Do you drink alcohol ?	<input type="radio"/> Yes <input type="radio"/> No	If yes: How often per day/week?	
Do you eat chocolate ?	<input type="radio"/> Yes <input type="radio"/> No	If yes: How often per day/week?	
Do you use marijuana ?	<input type="radio"/> Yes <input type="radio"/> No	If yes: How often?	
Do you use cocaine ?	<input type="radio"/> Yes <input type="radio"/> No	If yes: How often?	
Are you pregnant ?	<input type="radio"/> Yes <input type="radio"/> 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? <input type="radio"/> Yes <input type="radio"/> No		If yes, please list the brand:	
Do you have a living will? <input type="radio"/> Yes <input type="radio"/> 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?

☐ Yes ☐ No

Signature of Patient or Legal Guardian

Print Patient's Name or Legal Guardian

Relationship to Patient

Witness Signature: _____

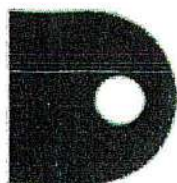
Date: ____/____/____

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? <input type="radio"/> Yes <input type="radio"/> 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? <input type="radio"/> Yes <input type="radio"/> 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: _____

NOTICE TO ALL PATIENTS

IF YOU ARE PLANING TO SCHEDULE A
SURGERY:

PLEASE MAKE EVERY EFFORT TO SCHEDULE AT A TIME
WHEN YOU ARE NOT ON YOUR MENSTRUAL CYCLE

PLEASE NOTIFY THE DOCTOR IF YOU ARE TAKING
ANTI-DEPRESSANTS. THIS MAY REQUIRE

D ADDITIONAL LAB WORK PRIOR TO SURGERY.

UNDERSTAND THAT SURGERY MAY BE
RESCHEDULED DUE TO ABNORMAL LAB RESULTS.

**PLEASE REVIEW THE MEDICATION SHEET.
NO ASPIRINS, IBUPROFEN, NSAIDS, VITAMIN E
AND MULTIVITAMINS. YOUR SURGERY WILL
BE CANCELLED IF TAKEN WITHIN TWO WEEKS
OF SURGERY. SURGERY CAN BE RESCHEDULED
BUT NO REFUNDS.**

DIACO INSTITUTE OF PLASTIC SURGERY PATIENT REGISTRATION

THESE ARE MEDICATIONS THAT THE PATIENT **MUST AVOID** 14 DAYS PRIOR TO
AND FOLLOWING SURGERY

If you are taking any medications on this list, you must discontinue use **14 days** prior and following surgery. All medications you are currently taking that are not on this list must be cleared by the doctor prior to surgery. Do not begin taking any medications following surgery until cleared by the doctor. "Regular Strength" Tylenol may be taken for pain prior to and following surgery.

****Do not take any Multivitamin, Vitamin E, or Aspirin containing products****

Aspirin Medications



4-Way Colds
Adprin-B Products
Anacin Products
Arthritis Pain Formula
Asacol
Azdone
Azulfidine Products
Bayer Products
Buffered Aspirin
Buffex
Compound
Cope
Carisoprodol
Cortisone
Dipentum
Disalcid
Doan's Products
Ecotrin Products
Empirin Products
Gensan
Genprin
Halfprin Products
5-AminoSalicylic Acid

Amigesic
Alka-Seltzer Products
Anexsia with Codeine
Arthritics Strength BC
Arthropan
Asprimox Products
Axotal
B-A-C
BC Powder
Bufferin Products
Cama Arthritis Pain
Cheracol
Crissalicylate
Coricidin
Darvon Compound-65
Darvon/ASA
Easprin
Equagesic
Fiorinal Products
Gelpirin
Isolyl Improved
Lortab ASA

Acetilsalicylic Acid
Mesalamine
Argesic-SA
Aspirin
Aspergum
Ascriptin Products
Backache Maximum
Bismatrol Products
Buffetts II
Butalbital
Butal/ASA/ Caff
Choline Magnesium
Choline Salicylate
Damason
Dolobid
Dristan
Duragesic
Excedrin Products
Fiorgen PF
Good's Extra Strength
Headache Powders
Kaodene
Lanorinal

813.876.3611
fax 813.387.1745

Manaprin Products
Marnal

Mobidin
Norgesic Products
Cold Effervescent
Orphengesic Products
Panasal
Percodan Products
Salflex
Phenaphen/Codeine #3
Salixylate Products
Scot-Tussin Original 5
Sine-off
Sodol Compound
Sulfasalazine
Synalgos-DC
Tricosal
Tussirex Products
Wesprin
Magnesium Salicylate
Marthritic
Methocarbamol

Mobigesic
Momentum
Night-Time Cold
Olsalazine
Pabalate Products
Pentasa
Pink Bismuth
Roxeprin
Propoxyphene Products
Salsalate
Soma Compound
Supac
Talwin
Trilisate
Ursinus-Inlay
Willow Bark
Zoprin
Magan
Magsal
Meproamate
Micrainin
Momo-Gesic
Norwhich Products

P-A-C
Pain Reliever Tabs
Pepto-Bismal
Rowasa
Robaxisal
Saleto Products
Salsitab
Sinutab
Sodium Salicylate
St. Joseph Aspirin
Suprax
Triaminicin
Tussanil DH
Vanquish
Tylenol Cold

Ibuprofen Medications

Actron
Aleve
Cataflam
Diclofenac
Etodolac
Flubiprofen
IBU
Ibuprohm
Indomethacin Products
Lodine
Mefenamic Acid
Motrin Products
Naprelan
Naproxen
Orudis Products
Piroxicam
Relafen
Sulindac
Tolmetin
Acular (ophthalmic)

Anaprox
Clinoril
Dimetapp Sinus
Feldene
Genpril
Ibupin
Indochron E-R
Ketoprofen
Meclofenamate
Menadol
Nabumetone
Naprosyn Products
Nuprin
Oruvail
Ponstel
Rhinocaps
Suprofen
Toradol
Advil
Ansaid

Daypro
Dristan Sinus
Fenoprofen
Haltran
Ibuprofen
Indocin Products
Ketorolac
Meclomen
Midol Products
Nalfon Products
Naprox X
Ocufen (ophthalmic)
Oxaprozin
Profenal
Sine-Aid Products
Tolectin Products
Vicoprofen
Voltaren

Diet/Weight Reduction Medications

Accutrin
Adipex
Diet Suppressant

Phenetermine
Redux
Fenfluramine.

Anti-Depressant Medications

Adapin
Anafranil
Clomipramin
Elavil
Imipramine
Nortriptyline
Protiptyline
Trofranil
Effexor
Amitriptyline

Asendin
Desipramine
Endep
Janimine
Pamelor
Sinequan
Triavil
Amoxapine
Aventyl
Doxepin

Etrafon
Limbital Products
Pertofrane
Surmontil
Vivactil
Wellbutrin
Bupropion
Celexa

Other Medications

4-way with Codeine
Actifed
Anturane
Celebrex
Coumadin
Ephedra
Flagyl
Garlic
Macroclantin
Opasal
A-A Compound
Anexsia
Arthritis Bufferin
Clinirol C
Dalteparin Injections
Emagrin
Fragmin Injections
Ginkgo Biloba
Isollyl

ACA
Anisindione
BC Tablets
Contac
Dicumerol
Furadantin
Hydrocortisone
Heparin
Lovenox Injection
Accolate
Pan-Pac
Prednisone
Pyrroxate
Sinex
Sparine
Tenuste Dospan
Ticlopidine
Miradon
Pentoxifylline

Phenylpropanolamine
Salatin
Sofarin
Stelazine
Trental
Warfarin
Persantine
Protamine
Ru-tuss
Soltice
Sulfinpyrazone
ThroazineTenuate
Ursinus
Vioxx
Topamax
VITAMIN E
MULTIVITAMINS

I have reviewed the medications on this list, understand that these medications need to be avoided **14 days** prior to and following surgery, and I understand that my surgery will be rescheduled if I take any of these medications within 14 days or less from my surgery. I also acknowledge that I have received my own copy of these medications to take home and review. I also understand that it is my responsibility to ask the doctor about my medications, not on this list, that I am taking.

Signature _____ **Date:** _____