DIACO INSTITUTE of PLASTIC SURGERY
TAMPA, FLORIDA

REASON FOR CONSULTATION

Name: _____

- ☐ Breasts
- ☐ Face
- ☐ Eyes
- ☐ Forehead
- ☐ Nose
- ☐ Chin
- ☐ Lips
- ☐ Wrinkles
- ☐ Body
- ☐ Brazilian Butt Lift
- ☐ Tummy
- ☐ Arms
- ☐ Legs
- ☐ Ears
- ☐ Juvederm/ Restylane/ Dermal fillers
- ☐ Botox
- ☐ Skin Tightening
- ☐ Laser Hair Removal
- ☐ Diva/ Vaginal Rejuvination
- ☐ Phototherapy/ BBL- sun damage, age spots, redness
- ☐ Halo Laser
- ☐ Profractional Laser
- ☐ Pigmented or Vascular Areas
- ☐ Mole/ Cyst Removal
- ☐ Men's Procedures
- ☐ Aesthetic Services
- ☐ Skin Care Products
- ☐ Other: _____

☐ If you would like to be added to our mailing list for monthly specials, please provide your email.

_____

DIACO INSTITUTE
of PLASTIC SURGERY

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 ➡

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:**_____

DIACO INSTITUTE of PLASTIC SURGERY

MEDICAL HISTORY

Do you have any allergies Yes No

If yes, please list, (including food and drug)

Do you have any current **MEDICAL PROBLEMS?** Yes No

If yes, please list:

Do you have any infectious diseases such as:

Hepatitis B: Yes No

Hepatitis C: Yes No

HIV positive: Yes No

MRSA (Methicillin-resistant Staphylococcus Areus) Yes No

Other staph resistant infections: Yes No If yes, please list:_____

AIDS:

Are you currently taking any **MEDICATIONS OR VITAMINS?** Yes No

If yes, please list here:

Is there a history of **MEDICAL PROBLEMS** in your family? Yes No

If yes, please list family member(s) & problem(s) (Example: cancer, diabetes, heart disease)

Have you ever been **HOSPITALIZED?** Yes No

If yes, please list date and reason:

Have you ever had an **OPERATION?** Yes No

If yes, please list and include dates:

Have you ever had a **SERIOUS ACCIDENT?** Yes No

If yes, please list and include dates:

If parent(s) are deceased, please list age and cause of death:

Mother: Age: Cause of death:

Father: Age: Cause of death:

DIACO INSTITUTE of PLASTIC SURGERY
TAMPA, FLORIDA

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 ➡

DIACO INSTITUTE
of PLASTIC SURGERY

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: ____/____/____

DIACO INSTITUTE
of PLASTIC SURGERY
MIAMI, FLORIDA

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: _____

ASPS Member Surgeon®

Authorization for and Release of Medical Photographs, Slides, and/or Video Footage

VIDEOTAPE AND PHOTOGRAPHS RELEASE AND AUTHORIZATION

I hereby irrevocably consent to and authorize the use and reproduction by the Daniel S. Diaco, M.D., P.A., and its affiliates, or anyone authorized by any of them, of any and all photographs, electronic images, or video footage of me taken by Daniel S. Diaco, M.D., P.A., or that Daniel S. Diaco, M.D., P.A., has in its possession, provided either by me or by a third party (collectively, Images) for the purpose of informing the medical profession and the general public about plastic surgery and plastic surgery procedures and techniques without compensation to me. Such use shall include, but not be limited to, distributing the Images via print, visual, and electronic media, specifically including the dr.diaco.com website and social media sites such as YouTube, Facebook, Instagram, and Twitter. The Images (including any photographic negatives) shall be the sole property of Daniel S. Diaco, M.D., P.A. Daniel S. Diaco, M.D., P.A., also shall have the right to use my name in connection therewith if it so chooses.

I hereby waive any right to inspect or approve the finished product, photograph, video, DVD, CD-ROM, or matter that may be used in conjunction therewith or to the eventual use that it might be applied.

I hereby release, discharge, and agree to hold harmless Daniel S. Diaco, M.D., P.A., and its affiliates and their respective representatives, assigns, and employees, and any person acting under their permission or authority, from and against any claims whatsoever in connection with the use of my Images and name and the reproduction thereof as stated above, including any claim for payment in connection with distribution or publication of the video and/or photographs.

I hereby warrant that I am over twenty-one years of age and competent to contract in my own name insofar as the above is concerned.

I have read and understand the foregoing release, authorization, and agreement, before signing my name below, and enter into it knowingly and voluntarily.

Date/Time:_____ Printed Name:_____

Signature:_____

I have read the above Release and Authorization. I am the parent, guardian, or conservatory of _____, a minor. I am authorized to sign this authorization on his/her behalf and I give this authorization in the interest of public education.

Date/Time:_____ Printed Name: _____

Signature: _____

_____ **Patient Initials**

This form is for reference purposes only. It is a general guideline and not a statement of standard of care. Rather, this form should be edited and amended to reflect policy requirements of your practice site(s), CMS and Joint Commission requirements, if applicable, and legal requirements of your individual states. The ASPS does not certify that this form, or any modified version of this form, meets the requirements to obtain informed consent for this particular procedure in the jurisdiction of your practice.

813.876.3611
fax 813.387.1745

DIACO INSTITUTE oF PLASTIC SURGERY
300 S. Hyde Park Ave. #100 Tampa, Florida 33606

NOTICE TO ALL PATIENTS

IF YOU ARE PLANNING 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 ADDITIONAL LAB WORK PRIOR TO SURGERY. UNDERSTAND THAT SURGERY MAY BE RESCHEDULED DUE TO ABNORMAL LAB RESULTS.

YOU MUST DISCONTINUE ANY WEIGHT LOSS INJECTABLES, AT LEAST 7 DAYS PRIOR TO SURGERY, OR SURGERY WILL BE CANCELLED.

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.

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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-AminoSalicyclic 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
Isollyl 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

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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
Meprobamate
Micrainin
Momo-Gesic
Norwhich Products

P-A-C
Pain Reliever Tabs
Pepto-Bismal
Rowasa
Robaxisal
Saleto Products
Salsitab
Simtab
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 (opthalmic)

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 (opthalmic)
Oxaprozin
Profenal
Sine-Aid Products
Tolectin Products
Vicoprofen
Voltaren

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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
Limbitrol Products
Pertofrane
Surmontil
Vivactil
Wellbutrin
Buproprion
Celexa

Other Medications

4-way with Codeine
Actifed
Anturane
Celebrex
Coumadin
Ephedra
Flagyl
Garlic
Macrodantin
Opasal
A-A Compound
Anexsia
Arthritis Buffexin
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
Pentoxyfylline
Phenylpropanolamine
Salatin
Sofarin
Stelazine
Trental
Warfarin
Persantine
Protamine
Rn-tuss
Soltice
Sulfinpyrazone
ThrozineTenuate
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 of 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:_____

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