

PESTANA AND PESTANA, MD, P.A.  
3100 CORAL HILLS DRIVE. SUITE #201  
CORAL SPRINGS, FL 33065

NAME OF PATIENT: \_\_\_\_\_ Chart I.D. \_\_\_\_\_  
REASON FOR CONSULTATION: \_\_\_\_\_

ALLERGIES TO MEDICINES: YES ( ) NO ( ) \_\_\_\_\_  
IF YES, TO WHICH? \_\_\_\_\_

DO YOU SMOKE? \_\_\_\_\_ DRINK? \_\_\_\_\_

DO YOU HAVE ASTHMA OR HAY FEVER? YES \_\_\_ NO \_\_\_

HAVE YOU EVER HAD A BAD REACTION TO A GENERAL ANESTHETIC (GAS,  
PENTHOTAL,ETC) ? \_\_\_\_\_ YES \_\_\_ NO \_\_\_

HAS ANYONE IN YOUR FAMILY HAVE MALIGNANT HYPERTHERMIA? YES \_\_\_ NO \_\_\_

HAS ANYONE IN YOUR FAMILY EVER HAD ANY BAD REACTION TO A GENERAL  
ANESTHETIC? \_\_\_\_\_ YES \_\_\_ NO \_\_\_

HAVE YOU EVER HAD A BAD REACTION TO A LOCAL ANESTHETIC? YES \_\_\_ NO \_\_\_

ARE YOU ALLERGIC TO ADHESIVE TAPE? \_\_\_\_\_ YES \_\_\_ NO \_\_\_

ARE YOU A SLOW OR POOR HEALER? \_\_\_\_\_ YES \_\_\_ NO \_\_\_

DO YOU FORM LARGE SCARS OR KELOIDS? \_\_\_\_\_ YES \_\_\_ NO \_\_\_

DO YOU BLEED UNUSUALLY EASILY (from cuts, surgery, tooth extractions) YES \_\_\_ NO \_\_\_

DO YOU BRUISE UNUSUALLY EASILY? \_\_\_\_\_ YES \_\_\_ NO \_\_\_

DO YOU HAVE HIGH BLOOD PRESSURE? \_\_\_\_\_ YES \_\_\_ NO \_\_\_

HAVE YOU EVER HAD SCARLET FEVER OR RHEUMATIC FEVER? \_\_\_\_\_ YES \_\_\_ NO \_\_\_

DO YOU HAVE ANY SKIN DISEASE, HIVES, ECZEMA OR RASH? \_\_\_\_\_ YES \_\_\_ NO \_\_\_

DO YOU HAVE FREQUENT INFECTIONS OR BOILS? \_\_\_\_\_ YES \_\_\_ NO \_\_\_

HAVE YOU TAKEN STEROIDS, CORTISONE OR ACTH? \_\_\_\_\_ YES \_\_\_ NO \_\_\_

DO YOU HAVE SHORTNESS OF BREATH? \_\_\_\_\_ YES \_\_\_ NO \_\_\_

DO YOU HAVE OR EVER HAD ANY EMOTIONAL PROBLEMS? \_\_\_\_\_ YES \_\_\_ NO \_\_\_

HAVE YOU EVER HAD PSYCHIATRIC CARE? \_\_\_\_\_ YES \_\_\_ NO \_\_\_

HAVE YOU EVER BEEN ADVISED TO SEE A PSYCHIATRIST? \_\_\_\_\_ YES \_\_\_ NO \_\_\_

ARE YOU ON BIRTH CONTROL PILLS? \_\_\_\_\_ YES \_\_\_ NO \_\_\_

HAVE YOU EVER BEEN EXPOSED TO OR HAD A HISTORY OF AIDS? YES \_\_\_ NO \_\_\_

ARE YOU ON AIDS TREATMENT AT THE PRESENT TIME? \_\_\_\_\_ YES \_\_\_ NO \_\_\_

DO YOU HAVE ANY HISTORY OF ARTHRITIS, LUPUS, SCLERODERMA? YES \_\_\_ NO \_\_\_

ARE YOU ON TREATMENT FOR ARTHRITIS AT THE PRESENT TIME? YES \_\_\_ NO \_\_\_

PLEASE, LIST **ALL** MEDICATIONS YOU ARE NOW TAKING, INCLUDING ASPIRIN,  
ETC: \_\_\_\_\_

ARE YOU TAKING ANY DIET PILLS? YES \_\_\_ NO \_\_\_ REDUX \_\_\_ PHENPHEN \_\_\_\_\_

Have you had any of the following illnesses, circle if yes:

Brain    Bladder    Intestines    Neck    Arms    Eyes    Heart    Kidneys

Nervous System    Reproductive System    Ears    Chest    Legs    Nose

Throat    Stomach    Lungs

HAVE YOU EVER HAD GENITAL HERPES? YES \_\_\_ NO \_\_\_ ORAL HERPES? YES \_\_\_ NO \_\_\_

If circled, please explain: \_\_\_\_\_

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

PESTANA & PESTANA, M.D., P.A.  
IVO D PESTANA, M.D.  
DIPLOMATE OF THE AMERICAN BOARD OF PLASTIC SURGERY  
3100 CORAL HILLS DR., SUITE # 201  
CORAL SPRINGS, FL 33065

**TO OUR PLASTIC AND RECONSTRUCTIVE PATIENTS**

**YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE  
INSURANCE**

Under Florida law, Physicians are generally required to carry malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice.

Due to the Malpractice Crisis in Florida, Doctor Ivo D. Pestana has decided not to carry Malpractice Insurance. This is permitted under the Florida law subject to certain conditions Florida law imposes penalties against noninsured physicians who fail to satisfy adverse judgments from claims of medical malpractice. This notice is provided pursuant Florida Law.

Any physician who fails to satisfy a malpractice claim against them will receive an emergency suspension of his Florida License.

Any physician that goes bare must do the following: Upon entry of an adverse final judgment in a medical malpractice case pay the plaintiff the lesser of the amount of the judgment or either \$100,000 (if the physician does not have hospital privileges) or \$250,000 (if the physician does have hospital privileges) Payment must be made within 60 days of the judgment becoming final.

I have read the above and understand it.

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_

WITNESS \_\_\_\_\_

PESTANA & PESTANA, MD., PA.  
IVO D. PESTANA, M.D.  
PLASTIC & RECONSTRUCTIVE SURGERY  
DIPLOMATE OF THE AMERICAN BOARD OF PLASTIC SURGERY  
3100 CORAL HILLS DRIVE, SUITE #201  
CORAL SPRINGS, FL 33065  
954-755-8844

Dear Patient,

If you are planning to finance your surgical procedure through your American Express, Visa and/or Master Card, Discover Card, we want to stress the fact that plastic surgery is not a product. Therefore, we cannot guarantee or warranty results. We will not accept any charge backs from your credit card company in case you voice some dissatisfaction on this procedure. The only way we can accept your credit card is by your signature below on accepting there terms as stated above.

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
WITNESS

\_\_\_\_\_  
DATE

PESTANA & PESTANA, MD., PA.  
IVO D. PESTANA, M.D.  
PLASTIC & RECONSTRUCTIVE SURGERY  
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CORAL SPRINGS, FL 33065  
954-755-8844

TO OUR PATIENTS.....IN REGARDS TO YOUR COSMETIC PROCEDURE

You must understand that the doctor cannot give you a PERFECT result. This is a fact of life. If you expect a perfect result then you still have the option of postponing or canceling your procedure.

In cases where the patient may require a revision, there will be no professional fee charged to you. However, if the revision is done here in the office, there will be a nominal fee of \$600.00 which is charged to every patient for supplies. If the revision is done at another facility, other than the office, you will incur additional fees for that facility.

If you require anesthesia, which will be given by a different professional, you will need to pay a separate fee to the anesthetist.

I understand the above and accept the terms.

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
WITNESS

\_\_\_\_\_  
DATE

# Pestana & Pestana, MD., PA

3100 Coral Hills Dr. Suite 201

Coral Springs, FL 33065

PH: (954) 755-8844 FAX: (954) 755-0272

## Authorization for Release of Information

I hereby authorize the release of records for:

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Relationship to Patient:  
\_\_\_\_\_

I understand that these records are privileged and confidential and cannot be released to those or myself designated by me or my legal guardian without this consent.

Unless otherwise specified below, I authorize the release of **ALL** medical records to the office of Pestana & Pestana, M.D., P.A.

If there are *exceptions* of records you wish to **withhold** from being released, please list them: \_\_\_\_\_

\_\_\_\_\_

**I understand that if I have listed any records above, they will not be released.**

I understand and agree that I am financially responsible for the fees associated with my request; copying charges, including the cost of the supplies, labor, and postage related to the production of my information deemed by the physician whose records are being requested.

I understand this information includes copies of all progress notes for well visits, acute sick visits, immunization records, consult notes, and if applicable information about HIV or AIDS. Information about substance abuse treatment and information pertaining to mental health services will also be provided. Unless I have indicated above that I wish to have such records withheld and not released.

I understand that I have the right to withdraw the authorization at any time except to the extent that action has already been taken pursuant to the authorization. I must do so in writing and present the written revocation to this office. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of the information and is no longer protected by federal confidentiality laws.

*UNLESS OTHERWISE REVOKED, THIS AUTHORIZATION WILL EXPIRE ONE YEAR FROM DATE OF SIGNATURE.*

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

\_\_\_\_\_

# ***Pestana & Pestana, MD.***

3100 CORAL HILLS DR., SUITE 201  
CORAL SPRINGS, FL 33065  
Phone (954) 755-8844

## PHOTOGRAPHIC CONSENT

I hereby voluntarily grant permission to Dr. Ivo Pestana and his designated representatives, staff or employees, to take and use any pre-operative, intra-operative or post operative photographs of myself for purposes of record, insurance information, educational purposes, & marketing reasons. Your identity will be concealed.

PLEASE CHECK **ONE** OF THE FOLLOWING *AFTER* READING *THOROUGHLY*:

- YES, I consent my pictures being used for the purpose of record, insurance information. Also for educational & marketing purposes as long as all efforts to conceal my identity are made.
- NO, I do not consent the use of my pictures for marketing and educational purposes but however, I do consent my pictures for the use of record and for insurance information.

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
WITNESS SIGNATURE

\_\_\_\_\_  
DATE

I hereby certified that I am a parent, or the person legally appointed as the guardian of the above patient, a minor person, and that I also hereby provide authorizations and grant releases described above in this document.

\_\_\_\_\_  
PARENT/ LEGAL GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE

PESTANA & PESTANA MD, P.A.  
3100 CORAL HILLS DRIVE SUITE 201  
CORAL SPRINGS, FL 33065

IVO PESTANA, MD  
TATIANA PESTANA, MD

Botox/Laser

**PATIENT INFORMATION (PLEASE PRINT LEGIBLY)**

Name \_\_\_\_\_ Age \_\_\_\_\_

SSN \_\_\_\_\_ DOB \_\_\_\_\_ Sex M / F

Home Phone \_\_\_\_\_ Wk Ph \_\_\_\_\_ Cell Ph \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

MARRIED \_\_\_\_\_ SINGLE \_\_\_\_\_ WIDOWED \_\_\_\_\_ DIVORCED \_\_\_\_\_

**Name & Number of Emergency Contact** \_\_\_\_\_

**REFERRED BY** \_\_\_\_\_ **REASON** \_\_\_\_\_

**Allergies to Medications** \_\_\_\_\_ **Current Medications** \_\_\_\_\_

FORM OF PAYMENT: CASH CHECK CREDIT CARD

DO YOU WISH TO RECEIVE INFORMATION REGARDING PLASTIC SURGERY VIA E MAIL Y / N  
EMAIL ADDRESS \_\_\_\_\_

I understand that I am financially responsible for all charges incurred in this office regardless of insurance or litigation coverage. I understand that assignment of benefits is not accepted as payment in full in those cases in which this practice does not participate in my insurance program. In the event that my bill is not already paid in full, I assign payment of these benefits I am entitled under the revisions of my insurance coverage to Pestana and Pestana, M.D., P.A. Please, we would appreciate that you let us know if you belong to any of the health insurance programs in which we participate as this may affect your financial responsibility. If payment is not made to this office, patient is responsible for 35% additional collection and 25% attorney's expenses incurred for collection. If more that one billing is necessary to collect payment (after insurance payment, if applicable a \$10.00 billing fee will be added to all subsequent billing statements. Please be aware that plastic surgery costs applied to a credit card are not entitled to a refund unless authorized by the physician. If you have any questions, please do not hesitate to ask us, we will be more than glad to assist you.

I HAVE RECEIVED AND READ THE "NOTICE OF PRIVACY PRACTICES", OF THE PESTANA AND PESTANA, M.D. P.A. OFFICE.

NAME \_\_\_\_\_ DATE \_\_\_\_\_

WITNESS \_\_\_\_\_ DATE \_\_\_\_\_

# ***Pestana & Pestana, MD., PA***

## ***Dr. Ivo & Tatiana Pestana, M.D.***

3100 Coral Hills Dr. Suite 201  
Coral Springs, FL 33065  
PH: (954) 755-8844 FAX: (954) 755-0272

Aesthetic Plastic Surgery  
Diplomat of the American Board  
of Plastic Surgery Fellow American  
College of Surgeons

### **ATTENTION ALL PATIENTS**

Dear Patients,

We would like to notify you that as of February 1<sup>st</sup> 2009, we will be applying a cancellation fee for any appointments not canceled with a 24 hour notice or if there is a failure to show to such appointment.

We would like to remind you that appointments are made so that the doctors can dedicate that time especially to you and your health concerns. When appointments are canceled without appropriate notice, this time is denied to other who might have benefited from it.

Our office requires a 24-hour time period for office visit cancellations. We reserve the right to charge a nominal fee of **\$50.00** for cancellations made after that time, as well as for un-kept appointments. Keep in mind that this fee is NOT covered insurance and will be billed to you.

Thank you for understanding.

I, \_\_\_\_\_, have read and understand the above office policy.  
PRINT NAME

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE