Pestana & Pestana, MD, PA

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 YOUBLEED UNUSUALLY EASILY (fromcuts,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 FRECUENT 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, MD, PA

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

I understand that charges made by the **OUTPATIENT CENTER or OUTPATIENT SERVICES** of the Hospital are approximate charges.

Although Dr. Pestana has tried to be as accurate as possible in calculating the time that he will spend performing the surgery, it is possible that the procedure may take longer. In that case, the Anesthesia Department and/or the Hospital/Outpatient Center **will charge me** for the additional time and I will be personally responsible to pay these additional fees.

Dr. Pestana's fees will not change. I understand and agree.

______________________________	________________
Signature	Date
______________________________	________________
Printed Name	
______________________________	________________
Witness	Date

Pestana & Pestana, MD, PA

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,

IVO D. PESTANA, M.D.
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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,

IVO D. PESTANA, MD
ELSA S. PESTANA, MD
3100 CORAL HILLS DRIVE, SUITE 201
CORAL SPRINGS, FL 33065
FAX 954-755-0272

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I, ____ authorize the Following
Patient/Parent/Legal Guardian/Legal Representative

Physician/hospital to release health information of

____ to
Name of Patient

______PESTANA AND PESTANA, M.D., PA.__________
NAME

3100 CORAL HILLS DR., SUTIE 201, CORAL SPRINGS FL 33065
ADDRESS

954-755-8844________________________954-755-0272________
PHONE FAX

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.

I authorize the release of the following information: **(PLEASE SELECT ALL THE APPLY)**

___ Entire Medical history, excluding____
___ History and Physical
___ Consultations
___ Discharge
___ Operative Reports
___ Physicians Orders
___ Physical Therapy Records
___ Radiology Reports
___ Laboratory Reports
___ Photo's
___ Pathology Reports
___ Immunization Records
___ Other

I understand that I have the right to withdraw my 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 my 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 BELOW.

____ ______________________________
Name/Parent/Legal Guardian/Personal Representative Date

Pestana & Pestana, MD

IVO D. PESTANA, MD
ELSA S. PESTANA, MD
3100 CORAL HILLS DRIVE, SUITE 201
CORAL SPRINGS, FL 33065
FAX 954-755-0272

PERMISSION TO SEND MEDICAL DOCUMENTS

I AUTHORIZE PESTANA AND PESTANA, MD TO SEND ANY PATHOLOGY REPORT, OPERATIVE REPORT, OFFICE NOTE OR ANY OTHER MEDICAL DOCUMENT REQUESTED BY MY INSURANCE COMPANY FOR THE SOLE PURPOSE OF A REIMBURSEMENT OF PAYMENT FOR A MEDICAL CLAIM.

____
NAME OF PATIENT (Print)

____ _______________
PATIENT/GUARDIAN SIGNATURE DATE

____ _______________
WITNESS 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 or insurance information.

At times these photos that are taken of you will be used for educational & marketing purposes. All efforts to conceal your identity will be made.

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 and I understand I will be contacted before my picture is used in such way.

☐ 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.

IVO PESTANA, MD
3100 CORAL HILLS DRIVE SUITE 201
CORAL SPRINGS, FL 33065

COS

PATIENT INFORMATION (PLEASE PRINT LEGIBLY)

Name ____ Age______

SSN ___________________________DOB _______________ Sex: ☐ F ☐ M

Home Phone _________________________ Wk Ph __________________ Cell Ph __________________

Address _______________________________ City ___________________ State _____ Zip ____________

Employer _________________________________ Occupation ____________________

MARRIED ☐ SINGLE☐ WIDOWED ☐ DIVORCED☐

Name & Number of Emergency Contact ____

INSURANCE INFORMATION SUBSCRIBER RELATIONSHIP ___________________________

INSURANCE _______________________________ ID # ___________________ GRP #____________

INSURANCE PHONE: _______________________ CLAIM ADDRESS__________________________

SUBSCRIBERS NAME _____________________________SSN ___________________DOB_____________

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_______________
Patient Signature/ Legal Guardian/ Representative

WITNESS____DATE_______________

Pestana & Pestana, MD

IVO D. PESTANA, MD
3100 CORAL HILLS DRIVE, SUITE 201
CORAL SPRINGS, FL 33065
FAX 954-755-0272

Dear Patient,

If you decided to proceed with your procedure after consulting with Dr. Ivo D. Pestana please keep in mind to following:

1) Additional expenses for laboratory test, cultures, pathology, examination, & X-Rays, etc... Will be billed separately by the source providing the service.
2) The fee that you will be quoted in today's office visit is valid for 6 (Six) months and is subject to change after that time.
3) The estimated surgical fee that you will receive includes the surgery and all the reasonable post-operative care. If out of the ordinary complications develop, additional charges may be incurred.
4) If additional surgery is necessary, you may be subject to additional surgeon fees.
5) An appropriate nominal operating room facility fee and anesthesia charges if necessary will be requested.
6) To best serve our patients, if surgery must be cancelled for ANY reason, please notify our office immediately. Two (2) weeks notice is required for a refund.
7) All charges are due and payable at your pre-operative visit, and/ or two (2) weeks prior to surgery, which ever comes first.
8) **The $500.00 (Five Hundred) deposit fee required to schedule surgery is NON-REFUNDABLE upon cancellation.**

I have read and understood the explanations and policies listed above. I also understand that this is NOT a commitment to have surgery.

_______________________________ _______________________
PATIENT NAME (PRINT) DATE

____
PATIENT SIGNATURE

____
WITNESS