

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(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, 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

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.,PA

IVO D. 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, M.D.

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

PLEASE CHECK ___ IVO PESTANA, MD

ER

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

INSURANCE INFORMATION SUBSCRIBER RELATIONSHIP _____

INSURANCE _____ ID # _____ GRP # _____

INSURANCE PHONE: _____ CLAIM ADDRESS _____

SUBSCRIBERS NAME _____ SSN _____ DOB _____

EMPLOYER _____ EMPLOYER PH _____
ACCIDENT Y / N DATE OF ACCIDENT _____

WORKERS COMPENSATION Y / N CLAIM # _____

WORKCOMP REPRESENTATIVE _____ PH _____

REFERRED BY _____ REASON _____

Allergies _____ Current Medications _____

FORM OF PAYMENT CASH CHECK CREDIT CARD
NAME /ADDRESS OF NEAREST RELATIVE _____

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

Ivo D. Pestana, M.D., F.A.C.S

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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 1st 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