

Pestana & Pestana, MD., PA

3100 Coral Hills Dr., Suite #201, Coral Springs, FL 33065

Office: (954) 755-8844 Fax (954) 755-0272

DR. TATIANA A. PESTANA

IM

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 _____

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Office Use Only:

MR# _____

Name: _____ DOB: _____
FIRST LAST MM / DD / YEAR

Please list any Doctor that you wish to request medical records from.
(Include your previous Primary Care Physician & any Specialist you currently see.)

| | | PHONE: (____) _____ | Specialty: |
|----|-------------------------|--|----------------------|
| 1) | _____ Name of Doctor | FAX: (____) _____ | <input type="text"/> |
| 2) | _____ | PHONE: (____) _____ FAX: (____) _____ | <input type="text"/> |
| 3) | _____ | PHONE: (____) _____ FAX: (____) _____ | <input type="text"/> |
| 4) | _____ | PHONE: (____) _____ FAX: (____) _____ | <input type="text"/> |
| 5) | _____ | PHONE: (____) _____ FAX: (____) _____ | <input type="text"/> |
| 6) | _____ | PHONE: (____) _____ FAX: (____) _____ | <input type="text"/> |

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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: _____

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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

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Review of Systems for Initial Visit

Name of Patient: _____ Chart ID# _____

Reason for Consultation: _____

Allergies to Medications: YES () NO (). If so, what medications, and what type of reaction? _____

Do you smoke? YES () NO (). If so, how many packs a day, for how many years? _____

Do you drink alcohol? YES () NO (). If so, what type and how many drinks per day? _____

What do you do for a living? _____

Do you have or recently had (please circle):

- | | | | | | |
|------------------------|----------------------|---------------------|--------------------|----------------------|--------------|
| Constitutional: | Fevers | Night Sweats | Weight loss | Weight gain | |
| Eyes: | Vision Changes | Red Eyes | Dry Eyes | Eye Pain | Tearing |
| Ears: | Hearing loss | Ear ringing | Ear pain | Ear drainage | |
| Nose: | Nasal Congestion | Runny Nose | | | |
| Mouth: | Tooth Pain | Tooth decay | Mouth Sores | | |
| CV: | Chest pain | Heart Racing | Fatigue | Swelling | |
| Pulm: | Difficulty Breathing | Shortness of Breath | Cough | Wheezing | |
| GI: | Nausea | Vomiting | Stomach Cramps | Diarrhea | Constipation |
| | Blood in Stools | | | | |
| GU: | Trouble Urinating | Pain with Urination | Incontinence | | |
| Skin/Hair: | Rashes | Dry Skin | Moist/Clammy Skin | Hair Loss | |
| | Nail changes | | | | |
| Muscles: | Joint pain | Muscle pain | Muscle weakness | | |
| Neuro : | Limb weakness | Dizziness | Headache | Changes in sensation | |
| Blood: | Easy bleeding | Easy bruising | | | |
| All/Imm: | Hay fever | Itchy Eyes | Itchy nose | Frequent infections | |
| Psych: | Depression | Anxiety | Sleep disturbances | | |

Other: _____

Please list ALL medications you are taking at this time, including over-the-counter, vitamins, and herbal medicines: _____

Date: _____ Signature: _____

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To Our Valued Pediatric and Internal Medicine Patients

We would like to notify you that as of June 1st, 2005, we will be applying a cancellation fee for any appointments not canceled with a 24 hour notice.

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

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ATTENTION PATIENTS

If you have been prescribed bloodwork or radiological studies, and you *do not* hear from Dr. Pestana with your results, it is because **Dr. Pestana has not received them.**

If you do not hear from Dr. Pestana with your results within several days after your studies, **IT IS YOUR RESPONSIBILITY** to call the office with information about *where and when* you had your studies done, so that we may retrieve them. **Assume we have not received the results until Dr. Pestana calls you.**

Thank you,

Drs. Tatiana & Elsa Pestana

I have read, understood the above notification, and agree that I am responsible for notifying the office of when and where my studies were done. I understand that if I do not hear from the physician, I should assume she has not received the results, and any abnormal results have not been reviewed.

PRINT NAME

DATE

SIGNATURE (Patient, Parent or Legal Guardian)

WITNESS

