



PLASTIC • COSMETIC • RECONSTRUCTIVE SURGERY

Cambridge Professional Center • 3500 Old Washington Road, Suite 201 • Waldorf, MD 20603

(301)870-0600 • FAX (301)870-0609 • Email: Fontanaplsurg@aol.com

www.fontanacosmeticsurgery.com

**Patient Information**

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Male  Female

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Marital Status  Single  Married  Divorced  Widowed  Separated

Age \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Home Phone # (\_\_\_\_)\_\_\_\_-\_\_\_\_

Home Address \_\_\_\_\_ Cell Phone # (\_\_\_\_)\_\_\_\_-\_\_\_\_

(city)\_\_\_\_\_ (state)\_\_\_\_\_ (zip code)\_\_\_\_\_ Work Phone # (\_\_\_\_)\_\_\_\_-\_\_\_\_

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

Email address \_\_\_\_\_

Referred by  Dr. \_\_\_\_\_  Internet  
 Friend \_\_\_\_\_  Other \_\_\_\_\_

**Emergency Contact**

Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Home Phone # (\_\_\_\_)\_\_\_\_-\_\_\_\_ Cell Phone # (\_\_\_\_)\_\_\_\_-\_\_\_\_

**Personal Health History**

Primary Care Physician \_\_\_\_\_ Phone Number \_\_\_\_\_

**Medical Problems (Past and Present)**

- Abnormal Bleeding  Yes  No
- Allergies  Yes  No
- Anemia  Yes  No
- Arthritis  Yes  No
- Asthma  Yes  No
- Cancer \_\_\_\_\_  Yes  No
  - ▶ Chemotherapy  Yes  No
  - ▶ Radiation  Yes  No
- Cold Sores  Yes  No
- Diabetes  Yes  No
- Headaches  Yes  No
- Heart Disease  Yes  No
- Hepatitis  Yes  No
- HIV  Yes  No
- High Blood Pressure  Yes  No
- Migraines  Yes  No
- Seizures  Yes  No
- Stroke  Yes  No
- Thyroid Problems  Yes  No
- Other \_\_\_\_\_

**Pregnancies:**

Year \_\_\_\_\_  
\_\_\_\_\_

**Previous Surgeries**

Year \_\_\_\_\_ Reason \_\_\_\_\_  
\_\_\_\_\_

**Other Hospitalizations**

Year \_\_\_\_\_ Reason \_\_\_\_\_  
\_\_\_\_\_

**Medications: Prescriptions and Over-the-Counter**

Drug	Strength	Frequency Taken
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you take aspirin?  Yes  No \_\_\_\_\_

Do you take ibuprofen?  Yes  No \_\_\_\_\_  
(Advil, Motrin, Nuprin)

**Allergies**

Previous reaction to anesthesia  Yes  No  
▶ Describe: \_\_\_\_\_

Are you allergic to latex?  Yes  No

Are you allergic to any medications?  Yes  No

Drug	Reaction
_____	_____
_____	_____
_____	_____

**Social History**

Do you drink alcohol?  Yes  No

Do you currently smoke?  Yes  No

Have you smoked in the past?  Yes  No

Do you use recreational drugs?  Yes  No

For current smokers: I understand that smoking affects the blood supply to my tissues, which places me at increased risk for prolonged wound healing, blistering, and/or actual skin and tissue loss.

Signature x \_\_\_\_\_

**Family History**

	Age(s)	Significant Health Problems
▶ Father	_____	_____
▶ Mother	_____	_____
▶ Siblings	_____	_____
▶ Children	_____	_____

Has anyone in the family had any problems with anesthesia?  Yes  No

Has anyone in the family had unusual bleeding with surgery?  Yes  No

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature x \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**Consent and Simplified Adult Release for Photographs**

I understand that photographs are an objective measure used to evaluate a patient's condition. I consent to have my photographs taken by Don J. Fontana, M.D. PA for the purpose of medical documentation, patient education, and insurance verification in cases of reconstructive procedures.

I also understand that with my consent, I grant Dr. Fontana the permission to publish the same in whole or in part for illustration or promotion in any media.

Signature x \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_



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## INSURANCE INFORMATION

**Primary:** Company Name \_\_\_\_\_ Subscriber \_\_\_\_\_  
Policy Number \_\_\_\_\_ Group # \_\_\_\_\_  
Address \_\_\_\_\_  
Telephone # (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Secondary:**  
Company Name \_\_\_\_\_ Subscriber \_\_\_\_\_  
Policy Number \_\_\_\_\_ Group # \_\_\_\_\_  
Address \_\_\_\_\_  
Telephone # (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Guarantor:** \_\_\_\_\_ Telephone # (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

I authorize my physician, Don J. Fontana, M.D. PA, to release medical information concerning my diagnosis and treatment to my insurance company. I recognize that I am responsible for any remaining balance on my account. By signing below, I agree to the services provided by Don J. Fontana, M.D. PA and that I will be held responsible for these charges. Overdue accounts are subject to 1.5% interest charge per month (annual percentage rate of 18%) which will be imposed on all unpaid balance over 60 days from the date of service. If the bill is turned over to an attorney/collection agency, an additional 35% for the collection fee, plus any additional legal fees will be charged.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. Since we do not participate with your insurance, it is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance. You will need to contact your insurance company to see if precertification is required and if the services provided to you by Dr. Fontana are a covered procedure.

\_\_\_\_\_  
Patient Signature/Guarantor

\_\_\_\_\_  
Date

## Request for Confidential Handling of Health Information

Name: \_\_\_\_\_  
Last First MI

Date of Birth: \_\_\_\_\_  
MM/DD/YYYY

The following individual is involved in my health care. I give Don J. Fontana, M.D. PA permission to communicate with the person listed below as needed for my ongoing health care activities. If you wish to name more than one person, please attach a separate sheet listing the additional individual (s).

Name: \_\_\_\_\_  
Last First MI

Primary Phone: \_\_\_\_\_ Secondary Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_

Don J. Fontana, M.D. PA will acknowledge the individual you have named above as being involved in your health care activities until you notify us in writing of your intention to retract this permission. This notification is not intended as a replacement for an authorization to release protected health information. In the event the amount of information to be conveyed exceeds the minimal amount necessary for involvement in your ongoing health care activities, you or your personal representative must complete a valid authorization of release of information.

**I request the confidential handling of my health information as indicated above.**

\_\_\_\_\_  
**Printed Name of Patient or Authorized Representative**

\_\_\_\_\_  
**Relationship**

X \_\_\_\_\_  
**Signature of Patient or Authorized Representative**

\_\_\_\_\_  
**Date**

**Your request will remain in effect until you notify Don J. Fontana, M.D. PA in writing of your intention to terminate or modify this request for confidential handling of your health information.**