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.