FLORIDA COSMETIC SURGERY CENTER

Dennis R. Ward MD, Medical Director and Associates

201 Maitland Ave. – Suite 1017 Altamonte
Springs, FL 32701
(407) 831-4454 (407) 831-4559 Fax www.FloridaCosmeticSurgeryCenter.com
Email: info@floridacosmeticsurgerycenter.com

Today's Date:_____

PATIENT INFORMATION:

Patient Name:_____
Last First MI

Address:_____
Street Apt#

_____
City State Zip

Home Phone:( )_____ Cell:( ) _____ Work:( ) _____

I give Permission to leave a VM and/or TEXT message: on my **PHONE:** YES / NO on my **E-MAIL**: YES / NO

Email:_____

Date of Birth: _____ Age:_____ Sex: M / F Social Security #:_____-_____-_____

Number of Children: _____ Name of Spouse: _____

Circle one: Married/Single/Div/Sep/Wid Primary Language_____

Ethnicity:

American Indian or Alaskan Native	Native Hawaiian or Pacific Islander
Asian	White/Caucasian
Black or African American	Other:

Employer: _____ Occupation: _____

Employer Phone Number: ( ) _____

Primary Care Physician:_____
Name Phone #

PHARMACY NAME:_____ Phone: ( ) _____

EMERGENCY CONTACT: _____Phone: ( ) _____

Relationship to Patient:_____

I give permission for FCSC to give information about my care to:_____
_____

REFERRED BY:_____

FLORIDA COSMETIC SURGERY CENTER

COSMETIC INTEREST QUESTIONNAIRE

PATIENT NAME:_____ **DATE:**_____

Health issues and procedures or products of interest to me (please check all that apply).

- ☐ Injectable Treatment - BOTOX™
- ☐ Dermal Fillers - Juvederm™, Radiesse™, Restylane™
- ☐ Skin Care Advice
- ☐ Acne Treatments
- ☐ AHA and Glycolic Peels
- ☐ Hair Removal
- ☐ Laser Treatments
- ☐ Scar Treatments
- ☐ Body Contouring
  - ☐ Liposuction
  - ☐ Abdominoplasty/Tummy Tuck
  - ☐ Body/Thigh Lift
- ☐ Facial Surgery
  - ☐ Face lift
  - ☐ Neck lift
  - ☐ Rhinoplasty/Nose
- ☐ Breast Enhancement
  - ☐ Breast Augmentation
  - ☐ Mastopexy/Breast Lift
  - ☐ Breast Reduction
- ☐ Blepharoplasty/Eye Surgery
  - ☐ Brow lift
  - ☐ Other _____
- ☐ Other, Please specify _____

Please answer the following questions on a scale of 1 to 5 by circling the appropriate number.

When looking at my face in the mirror, I believe I look [YOUNGER, THE SAME AS, OR OLDER] than my true age.

Younger Than		*True Age*		*Older Than*
1	2	3	4	5

When looking in the mirror, I am [NOT, SOMEWHAT, OR VERY] concerned about the appearance of my wrinkles.

Not Concerned		*Somewhat Concerned*		*Very Concerned*
1	2	3	4	5

Physically, in my opinion, my greatest asset is _____

Physically, my top priority to improve is _____

Timeframe to Resolve My Concerns ☐ Immediately ☐ 2-6 Months ☐ 6-12 Months ☐ Just Gathering Information

I heard about Florida Cosmetic Surgery Center through:

- ☐ Friend or Family Member (name) _____
- ☐ Internet Search (Google, Bing etc.) _____
- ☐ Advertisement or Article (please specify)_____
- ☐ Other (please specify)_____

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Name:						**Birth Date:**		
Height:	**Weight:**					**Dominant Hand: R / L**		

Health History of Patient			**Family History**			**Review of Systems** - *Current or Recent?*		
Stroke	YES	NO	Stroke	YES	NO	Hoarseness	YES	NO
Seizures or Epilepsy	YES	NO	*Family Member:*			Nosebleeds	YES	NO
Migraine headaches	YES	NO	Heart Trouble	YES	NO	Difficulty Swallowing	YES	NO
Heart Trouble/Disease	YES	NO	*Family Member:*			Shortness of Breath	YES	NO
Murmurs, Irregular beat	YES	NO	High Blood Pressure	YES	NO	Persistent Cough (more than 3 weeks)	YES	NO
High Blood Pressure	YES	NO	*Family Member:*			Bloody mucus w/ cough	YES	NO
Bleeding Disorders	YES	NO	Diabetes	YES	NO	Chillls or Fever	YES	NO
Blood Transfusion	YES	NO	*Family Member:*			Night sweats	YES	NO
Phlebitis	YES	NO	Arthritis	YES	NO	Heart or Chest Pain	YES	NO
Blood clots in the legs	YES	NO	*Family Member:*			Abnormal Heartbeat	YES	NO
Anemia	YES	NO	Gout	YES	NO	Calf cramps w/ walking	YES	NO
Varicose Veins	YES	NO	*Family Member:*			Loss of Appetite	YES	NO
Diabetes	YES	NO	Kidney Trouble/Stones	YES	NO	Nausea or Vomiting	YES	NO
Thyroid Trouble	YES	NO	*Family Member:*			Abdominal pain	YES	NO
Arthritis	YES	NO	Gall Stones	YES	NO	Stomach/Intestinal ulcers	YES	NO
Gout	YES	NO	*Family Member:*			Blood w/ bowel movements	YES	NO
Kidney Trouble/Stones	YES	NO	Bleeding Disorders	YES	NO	Frequent Urination	YES	NO
Stomach/Intestinal Ulcers	YES	NO	*Family Member:*			Burning while urinating	YES	NO
Liver Trouble	YES	NO	Cancer	YES	NO	Depression	YES	NO
AIDS/HIV	YES	NO	*Family Member:*			Recent Weight Change (Loss/Gain)	YES	NO
Hepatitis	YES	NO	Alcoholism	YES	NO	Bruise easily	YES	NO
Jaundice	YES	NO	*Family Member:*			Scar badly	YES	NO
Pulmonary Embolism	YES	NO	Other:	YES	NO	Heal well	YES	NO
Bronchitis	YES	NO	*Family Member:*					
Shortness of breath	YES	NO				***Explain all YES answers - details of each condition. Use back if necessary***		
Asthma	YES	NO						
Emphysema	YES	NO	*****Drug ALLERGIES*****					
Tuberculosis	YES	NO	***YES*** ☐ ***NO*** ☐					
MRSA	YES	NO	Name Reaction					
Mental Illness	YES	NO						
Depression, emotional problem	YES	NO						
Cancer	YES	NO						
Serious Injuries	YES	NO				**Food Allergies:**		
Visual Impairment	YES	NO						
cataracts, glaucoma, dry eyes	YES	NO	**Misc ALLERGIES:**					
double vision	YES	NO	Latex	YES	NO			
Other Illnesses	YES	NO	Shellfish/Iodine	YES	NO			
			Other:					

Past or Present (Taken on a Regular Basis)			Currently wear:			Social History		
Aspirin	YES	NO	Glasses	YES	NO	***Smoke***	YES	NO
Advil / Nuprin / Motrin	YES	NO	Contacts	YES	NO	_____ pack(s)/day for _____years		
Tylenol	YES	NO	Crowns	YES	NO	If previous smoker, date of last use:		
Morphine / Codeine / Demerol	YES	NO	Bridges	YES	NO			
Other Pain Medications	YES	NO	Dentures	YES	NO	***Alcohol***	YES	NO
Steroids	YES	NO				_____ drinks of _____ per day/ week		
Valium	YES	NO				Date of last use:		
Anti-Depressants	YES	NO						
Hormones	YES	NO				***Drugs***		
Tranquilizer	YES	NO				Marijuana	YES	NO
Xylocaine	YES	NO				LSD/Acid	YES	NO
Penicillin / Keflex	YES	NO				Cocaine/Crack	YES	NO
Other antibiotics	YES	NO				Heroin	YES	NO
Diet Pills	YES	NO				Other:	YES	NO
Natural Herbs	YES	NO				Date of last use:		
Vitamins	YES	NO						

If yes to the above list dose, frequency, and duration of time taken:

Current Medications

Include prescriptions, diet pills, metabolic enhancers, vitamins, herbs and over the counter drugs

Surgery	Date	Medication	Dosage	Reason

I state that all information provided above is accurate. All medical conditions have been noted and all medications including over the counter medications are included. I acknowledge I have read and received a copy of the "Privacy Act" and have asked any questions regarding it. This facility is accredited by the Joint Commission for Patient Safety. Patients can report any concerns to www.jointcommission.org or call (630) 792-5000.

Signature _____ Date: _____

Name Printed: _____

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PHYSICIAN INFORMATION AND INSURANCE POLICY

Dr. Dennis Ward is an Orlando native and has resided in the area since 1953. He received a Bachelor of Arts in Biology in 1972 from Southern Missionary College in Collegedale, Tennessee. After his Bachelors he received his medical degree from Loma Linda School of Medicine in 1976. He completed his general surgical residency at USPHS Hospital Baltimore, Maryland which included rotations at Johns Hopkins and Baltimore Shock Trauma Unit. In 1983, Dr. Ward completed his senior fellowship for Plastic and Reconstructive Surgery at the University of Florida/Shand's Hospital. Dr. Ward has been a practicing physician in the state of Florida since 1981, and has been practicing Plastic and Reconstructive Surgery since 1983. With thirty years of experience, Dr. Ward has developed his practice with special interest in the Cosmetic area of Plastic Surgery.

Due to the current medical malpractice crisis, Dr. Ward does not carry medical malpractice insurance. Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against noninsured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice.

Please be advised we do not regularly accept insurance for treatments, procedures or surgeries at our office. Payments for all work done at our office are made in advance.

I have read and understand the above information and agree to the terms listed.

_____ _____

Patient Signature Date

_____

Name Printed

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PATIENT RESPONSIBILITIES AND ACKNOWLEGEMENT

_____Patient has provided accurate information to the best of their knowledge for the patient health history that includes present complaints, past illness, hospitalizations/surgeries, medications, any unexpected changes and other information listed in the forms.

_____Patient should ask questions if they need clarification or additional information on the instructions or information they have been given.

_____Patient should follow the preoperative, postoperative and discharge care plan as instructed. Any concerns should be expressed if they feel they are unable to follow or comply with the proposed care plan prior to treatment. Patient accepts responsibility for any changes they, their family or care giver make to the care plan.

_____Patient agrees to follow the rules and regulations of this practice concerning care of conduct. Patient and/or family should not access any areas designated "Staff Only" without accompaniment of a staff member.

_____Patient agrees to respect the privacy of other patients present in the office at time of treatment.

_____Patient agrees to obtain all necessary authorization(s) and/or referral(s) from any other physicians or facilities as required for treatment.

_____Patient agrees to remit full payment for services prior to treatment.

I acknowledge that I have read the above and given accurate information requested.

I have also received a copy of Florida Cosmetic Surgery Center Notice of Privacy Practices (see HIPAA Notice) and have read and understand its contents.

_____ _____
Patient Signature Date

_____
Name Printed

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AUTHORIZATION FOR AND RELEASE OF MEDICAL PHOTOGRAPHS AND/OR VIDEOTAPES

Read this information carefully and completely. After reviewing, please sign the consent as proposed by your plastic surgeon.

INTRODUCTION

Medical photographs and videotapes may be taken before, during, or after a surgical procedure or treatment. Consent is required to take such images. Additionally, patients may consent to release these medical photographs and videotapes for a stated purpose.

1. **Consent to Take photographs and/or videotapes** ❑ **Yes** ❑ **No**

I allow Dr. Dennis Ward M.D. and/or his associates to take pre-operative, intraoperative, and post-operative photographs *(before and after pictures)* and/or videotapes. I additionally consent to photographs and/or videotapes of any interview I may give.

2. **Consent for Release and Use of photographs and/or videotapes** ❑ **Yes** ❑ **No**

I agree to let Dr. Dennis Ward M.D. and/or his associates to use pre-operative, intra-operative, and post-operative photographs *(before and after pictures)* and/or videotapes for professional medical purposes deemed appropriate: including but not limited to patient education - before and after books, electronic digital media (website), brochures and marketing materials, or during lectures to medical or lay groups.

I understand that I will not be entitled to monetary payment or any other consideration as a result of any use of these images and/or my interview.

Patient Signature :_____ Date: _____

Witness: _____

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Cancellation and No-Show Policy

Our goal at Florida Cosmetic Surgery Center is to provide quality individualized care in a timely manner to every patient. Late cancellations and No-Shows create inconvenience and prevent scheduling of other patients who need access to the same care in a timely manner. We understand situations arise when you may need to cancel your appointment and we appreciate advanced notice when that happens. This helps us be respectful of other patients needs and enables us to give the appointment time to another patient who needs to see us.

Office Appointment

Please call our office by 3:00pm on the business day (Monday - Friday) prior to your scheduled office appointment or procedure to notify us if you need to reschedule or cancel the time that was reserved for you.

Office appointments which No-Show, or are rescheduled or cancelled without advanced notice will be subject to a **$75.00 Late Cancellation/No Show Fee**. This fee is your responsibility, and must be paid in full prior to scheduling your next appointment.

Thank you for being respectful of Dr. Ward's time, as it is his goal to give individual care in a timely manner to each patient who comes into our office.

_____ _____

Patient Name (printed) Patient Signature

_____

Date

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NOTICE OF PRIVACY PRACTICES (HIPAA NOTICE)

- This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.
- At Florida Cosmetic Surgery Center we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.
- The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.
- We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.
- We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.
- We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.
- We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.
- In an emergency, we may disclose your health information to a family member or another person responsible for your care.
- We may release some or all of your health information when required by law.
- If this practice is sold, your information will become the property of the new owner.
- We are required to obtain an authorization for any use or disclosure of protected health information for marketing purposes: except if the communication is (A) face to face or (B) a promotional gift of nominal value.
- We must obtain an authorization should the Practice sell Protected Health Information and gain from such sale.
- Protected health information may be used or disclosed for fundraising, and you as the individual shall have an opportunity to opt-out of future requests.
- We are required to obtain an authorization for use of psychotherapy notes except in the case where our office is the originator of such notes, in the event of training purposes, or where the notes are being disclosed for government or legal proceedings.

- Except as described above, this practice will not use or disclose your health information without your prior written authorization.
- You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.
- You have the right to know of any uses or disclosures we make with your health information beyond that above normal uses.
- As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.
- You have the right to transfer copies of your health information to another practice. We will mail your files for you.
- You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.
- You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove or alter earlier documents, but will add new information.
- You have the right to receive a copy of this notice.
- If we change any of the details of this notice, we will notify you of the change at your next appointment after the effective date of the change.
- We reserve the right to have your medical records and files reviewed by our corporation's attorney as part of our medical quality assurance.
  - You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, SW, Room 509-F, Washington, DC 20201. You will not be retaliated against for filing a complaint.
- However, before filing a complaint, for more information, or for assistance regarding your health information privacy please contact our office at 407-831-4454

This notice goes into effect as of September 23, 2013