FERNANDO G. SERRA, M.D.

PATIENT REGISTRATION

DATE:_____ EMAIL ADDRESS:_____

NAME AND PHONE NUMBER OF YOUR PHARMACY:_____

SOCIAL SECURITY # _____ FIRST NAME_____

DATE OF BIRTH_____ MIDDLE NAME/INITIAL_____

SEX_____MARITAL STATUS_____ LAST NAME_____

CHECK ONE: O EMPLOYED O RETIRED O STUDENT HOME ADDRESS_____

O OTHER_____ CITY_____STATE_____ZIP_____

EMPLOYER_____ HOME PHONE_____CELL PHONE_____

WORK PHONE_____ PREFERRED NUMBER TO CALL: HOME OR CELL

REFERRING PHYSICIAN _____

INSURANCE INFORMATION

CHECK ONE: O COMMERCIAL O MEDICARE O BLUE CROSS BLUE SHIELD O UNITED HEALTHCARE O OTHER

INSURANCE COMPANY_____POLICY #_____

INSURED/CARD HOLDER'S NAME_____GROUP #_____

RELATIONSHIP_____PHONE #_____

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY_____POLICY #_____

INSURED/CARD HOLDER'S NAME_____GROUP #_____

RELATIONSHIP_____PHONE #_____

SPOUSE / GUARANTOR / RESPONSIBLE PARTY

SOCIAL SECURITY #_____SEX_____ DATE OF BIRTH_____

RELATIONSHIP_____PHONE #_____

FIRST NAME_____LAST NAME_____

EMERGENCY CONTACT

NAME_____RELATIONSHIP_____PHONE #_____

ADDRESS_____

NOTICE OF PRIVACY PRACTICES: This is to certify that I have received a copy of the NOTICE OF PRIVACY PRACTICES, effective September 23, 2013, from Central Florida Plastic Surgery.

Patient signature_____Date_____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to Physician of the Surgical and/or Medical Benefits. If any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Physician to release any information acquired in the course of my treatment to process insurance claims.

Signature_____Date_____

HISTORY INTAKE FORM

How did you hear about Dr. Serra? _____
YOUR NAME_____ BIRTHDATE

_____

Please answer all of the questions as accurately as possible. If you do not understand a question, please ask for assistance.
Primary Care Doctor: _____

Smoker…….no yes amount per day _____ Alcohol use…….no yes type/amount per week _____

If former smoker, date quit _____ Weight _____ Height _____

Drug Allergies: _____

Novacaine/Lidocaine_____Epinephrine_____Iodine_____Shellfish_____Surgical Tape_____Latex_____

List previous surgeries or major illnesses and dates: _____

_____

List any medications you are taking <u>INCLUDING PRESCRIPTION STRENGTH</u>, non-prescription drugs, vitamins, herbals, blood thinners:

_____

_____

Have you had the following? Flu Shot…….no yes Date ___ _____

Pneumonia Shot……no yes Date _____

Colonoscopy...…….no yes Date_____

Past Medical History:
Have you ever had the following?

Heart Disease…….no yes	Cancer……no yes	Stomach Ulcer……..no yes
Arthritis…….no yes	Glaucoma……no yes	Kidney Disease……..…no yes
Rheumatic Fever…..no yes	Asthma……..no yes	Thyroid Disease……..…no yes
Anemia……..….no yes	Aids or HIV+….....no yes	Bleeding Tendency……..no yes
Tuberculosis……no yes	Stroke……no yes	Mitral Valve Prolapse….no yes
Diabetes…….no yes	Hepatitis……no yes	High Blood Pressure.....no yes

Review of Systems:
Do you have now or have you had within the past year?

Weight Change…….no yes	Swollen feet/ankles……..…no yes	Seizures…….....no yes
Dry Eyes……...no yes	Skin Rash……..no yes	Joint or Muscle Pain…...no yes
Chronic Cough……..no yes	Chronic Diarrhea……..no yes	Swollen Lymph Nodes....no yes
Chest Pain……no yes	Jaundice……no yes	Easy Bleeding……..no yes
Rapid Heart Beat….no yes	Depression……no yes	Easy Bruising……..…..no yes

Women Only:
Age period began_____
Date of last mammogram_____
Have you had a recent bone density test……..…..no yes Date _____

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

X_____ _____
Signature of patient or parent if minor. Date