



EAST LAKE
PLASTIC SURGERY CENTER

CONSENT FOR TAKING AND/OR PUBLISHING PHOTOGRAPHS

Patient Name: _____ Account. #: _____

I hereby grant authority to ISIDOROS MORAITIS, M.D. and/or his designated representatives to take photographs of myself/my child with the understanding that such photographs are for confidential clinical purposes of evaluation and treatment, and that all photographs remain the property of ISIDOROS MORAITIS, M.D.. I understand that the photographs are a permanent part of my medical record, and as such may be submitted to my insurance for the specific purpose of obtaining reimbursement for authorized services. I understand that the photographs may also be used for the purpose of certification of Isidoros Moraitis, M.D. by the American Board of Plastic Surgery.

Signed: _____ Print: _____ Date: _____

Office Witness: _____ Print: _____ Date: _____

IN ADDITION to use of these photographs for the purposes as previously stated, I consent to their use as specifically indicated below **(please check appropriate boxes to indicate approved choices):**

YES **NO**

My/my child's photographs may be used for the purpose of education or science, and as such may be published and republished with appropriate documentation in professional journals or medical books, or used for any other purpose which may be deemed proper in the interest of medical education, knowledge or research; provided however, that it is specifically understood that in such publication or use I shall not be identified by name.

YES **NO**

My/my child's photographs may be used for the purpose of patient/public education, and as such may be viewed by others. It is specifically understood that in such use of these photographs, I shall not be identified by name.

addendum _____

Signed: _____ Print: _____ Date: _____

Office Witness: _____ Print: _____ Date: _____



EAST LAKE
PLASTIC SURGERY CENTER

Patient Name: _____

Account #: _____

DESIGNATED RELATIVE

_____(Initial) I authorize discussion of my general medical condition and diagnosis (including treatment, payment and health care operations) with: *Please list the family members or significant others, if any, whom we may inform about your medical condition.*

Name: _____ Relation: _____ Phone #: (____) _____
Name: _____ Relation: _____ Phone #: (____) _____

PRIVACY NOTICE

_____(Initial) I have received a copy of ISIDOROS MORAITIS, M.D.'s office *privacy notice* as required by HIPAA that provides a complete description of *personal health information* uses and disclosures. I have been provided an opportunity to review it.

FINANCIAL POLICY

USUAL AND CUSTOMARY FEES: Our practice is committed to providing the best medical care for our patients. We charge what is usual and customary for our area. All patients are responsible for providing accurate and complete personal and insurance information prior to being seen by the doctor. The charges made, for your visit and care provided, depend on the nature and the complexity of your problem.

FORMS OF PAYMENT ACCEPTED: Payment may be in the form of cash, checks, Master Card and Visa. Returned checks are subject to a service charge. Elective Cosmetic Surgeries may also be paid in full with a *Cosmetic Fee Plan* or *Patient Financing Services* account.

PAYMENT FOR SERVICES (SELF-PAY/NON-INSURED): Payment in full is expected before services are rendered unless prior financial arrangements have been made.

PAYMENT FOR SERVICES (PERSONAL HEALTH INSURANCE/MEDICARE): Please be aware that some, and perhaps all, of the services provided may be non-covered services or may not be considered medically necessary under the Medicare Program or by your insurance company. In all cases, we require that the guarantor, the person who is financially responsible, is *personally* liable for all balances not covered by Medicare or other insurance. It is your responsibility to understand and comply with any predetermination of benefits or referral requirements. All charges are your responsibility from the date services are rendered. **CO-PAYMENTS:** Co-payments are due at the time of service.

PAST DUE ACCOUNTS: Any balances on your account after 90 days, including those that insurance has not paid, will be referred to a collection agency unless other financial arrangements have been made in advance. Legal fees that we pay to secure any past due balances will be added to your account. We realize that emergencies do arise and may affect timely payment of your account. If such extreme cases do occur, please contact us promptly for assistance in the management of your account.

WORKERS COMPENSATION: If you are seeking medical care as a result of a work-related injury, we will assist you in verifying your claim for the coverage of your medical bills. If for any reason your worker's compensation is not verified, the full responsibility for payment of services rendered will be that of the individual receiving treatment.

PAYMENT FOR ELECTIVE COSMETIC SURGERY: Payment in full is expected before services are rendered. Aesthetic (Cosmetic) surgeries will not be scheduled until your financial obligation has been met. Our office requires a minimum deposit of \$500 or 10% of the total surgeon's fee, whichever is greater, in order to schedule your surgery. This deposit will be applied to your "surgeon's fee" portion of the cost. Payment may be in the form of cash, checks, Master Card and Visa. If paying by credit card, the card must be presented in person by the authorized cardholder and a charge slip must be signed. Returned checks are subject to a service charge. Payment in full of the surgeon's fee must be received two (2) weeks prior to your scheduled procedure or we reserve the right to cancel or reschedule your surgery.

CANCELLATION OF ELECTIVE COSMETIC SURGERY: Should it become necessary for you to cancel or reschedule your surgery, we must receive notice of that change at least 10 days before your surgery date. If we receive notice of cancellation by that time, your deposit will be refunded in full. If you paid for your surgery with one of our financing companies offered, we will refund your financed portion of your payment minus 7%. If you should cancel your surgery three times, your deposit of \$500 or 10% paid will not be refunded and we will require a new deposit to reschedule your surgery. Exceptions will be made for documented emergency or medical disability.

REFUNDS FOR SKIN CARE SERVICES/PRODUCTS: Refunds will be made on pre-paid services that are not rendered, after regular prices are applied to those services already received. All SkinMedica home care products are 100% refundable within 30 days of purchase with receipt.

By signing this form, I fully understand and agree to the terms of the FINANCIAL POLICY.

Signed: _____ Print: _____ Date: _____

Office Signature: _____ Print: _____ Date: _____

WELCOME TO OUR PRACTICE!



Please take a moment to complete
this form so we can better assist you
with your health care needs.

EAST LAKE
PLASTIC SURGERY CENTER

PATIENT INFORMATION

Date: _____ Account # _____

Last Name _____ First Name: _____ MI: _____ SS #: _____

Sex: M F Age _____ Date of Birth _____ Marital Status: S M D W SEP

Parents' Names if Patient is a Minor: Mother: _____ Father: _____

Spouse or Partner's Name: _____

Mailing Address _____ City: _____ State: _____ Zip: _____

Phone # home: (____) _____ cell: (____) _____ E-Mail: _____

Occupation _____ Employer Name: _____ work#: (____) _____

If Student: Full-Time Part-Time Name of School: _____

Notify in Case of Emergency: _____ Relation: _____ Phone #: (____) _____

Primary Care Doctor: _____ Phone #: (____) _____

How did you here about us? CHECK ALL THAT APPLY ER Internet Yellow Pages Yellow Pages Local newspaper Other _____

Doctor _____ Name _____ Patient _____ Name (Optional) _____ Friend _____ Name (Optional) _____

CARRIER INFORMATION

Primary Insurance: _____

Carrier Address: _____ City: _____ State: _____ Zip: _____

Carrier Phone #: _____ Policy #: _____ Group #: _____

Name of Policy Holder if other than Patient: _____ Date of Birth: _____ SS#: _____

Relationship to Patient: _____

Secondary Insurance: _____

Carrier Address: _____ City: _____ State: _____ Zip: _____

Carrier Phone #: _____ Policy #: _____ Group #: _____

Name of Policy Holder if other than Patient: _____ Date of Birth: _____ SS#: _____

Relationship to Patient: _____

PERMISSION FOR TREATMENT

I hereby voluntarily consent to and authorize medical care/diagnostic treatment and /or minor surgical treatment by **ISIDOROS MORAITIS, MD** deemed advisable and necessary in the diagnosis and treatment of my condition. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office. I authorize the use and disclosure of any of my past/current medical records for treatment and healthcare operations.

Signed: _____ Print Name: _____ Date: _____

AUTHORIZATION AND ASSIGNMENT

I hereby assign all medical/diagnostic/surgical benefits payable for the services rendered, to include major medical benefits to which I am entitled, including Medicare, Private Insurance and other health plans to **ISIDOROS MORAITIS, MD, PA**. I hereby authorize said assignee to release to CMS/Insurance Carriers and it agents all information needed to determine these benefits or benefits related to services. I understand that any unpaid balance not covered by this policy will be payable by me. I understand and agree, regardless of my insurance status, that I am ultimately responsible for the balance of any professional services rendered. I understand that I am responsible for any charges incurred if my account is sent to a collection agency and for any returned checks. I understand that Medicare and/or other Insurance Carriers do not cover all office services/ procedures. I agree to take full responsibility for any unpaid balances and that such payment will be made to the said assignee for services.

Signed: _____ Print Name: _____ Date: _____

Office Witness: _____ Print Name: _____ Date: _____

THANK YOU FOR CHOOSING OUR PRACTICE!



Please take a moment to complete all information on this record. The information you provide is treated as confidential.

EAST LAKE
PLASTIC SURGERY CENTER

PATIENT HISTORY

Patient Name: _____ Account #: _____

Date: _____ Reason for your visit today: _____ Date of Injury, If Applicable: _____

Please list current medical conditions (Heart problems, diabetes, bleeding disorder, etc): _____

Medications currently taken on a regular basis (including over-the-counter and Herbs): _____

HAVE YOU **EVER** HAD:

| | | |
|--|---|--|
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> HIGH OR LOW BLOOD PRESSURE | <input type="checkbox"/> LIVER DISEASE |
| <input type="checkbox"/> LUNG PROBLEMS | <input type="checkbox"/> RHEUMATIC FEVER | <input type="checkbox"/> KIDNEY DISEASE |
| <input type="checkbox"/> SHORTNESS OF BREATH | <input type="checkbox"/> PAIN IN THE CHEST | <input type="checkbox"/> DIABETES/ INSULIN USE |
| <input type="checkbox"/> HEART MURMUR | <input type="checkbox"/> PAIN IN THE ARMS | <input type="checkbox"/> BLEEDING PROBLEMS |
| <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> DIZZINESS | <input type="checkbox"/> BREAST DISEASE |
| <input type="checkbox"/> HEART SURGERY | <input type="checkbox"/> CONVULSIONS | <input type="checkbox"/> GLAUCOMA |

ARE YOU ALLERGIC TO:

| | | |
|--|--|---|
| <input type="checkbox"/> FOODS _____ | <input type="checkbox"/> PENICILLIN | <input type="checkbox"/> DEMEROL |
| <input type="checkbox"/> SHELLFISH/ IODINE | <input type="checkbox"/> OTHER ANTIBIOTICS | <input type="checkbox"/> ANY ANESTHETIC _____ |
| <input type="checkbox"/> ASPIRIN | <input type="checkbox"/> CODEINE | <input type="checkbox"/> NOVOCAINE/LIDOCAINE |

Please list **any other allergies** not mentioned above: _____

Have you ever had a general anesthetic before? Yes No If Yes, for what? _____

Describe any problems you had with Anesthesia, if any: _____

Do you smoke? Yes No If yes, how often? _____ How many cigarettes per day? _____

Do you use any other tobacco products? Yes No If yes, how often? _____

Are you under the care of a physician at this time for any problem? Yes No If yes, please explain: _____

COSMETIC SURGERY/PROCEDURE PATIENTS ONLY:

Have you ever consulted a plastic surgeon? Yes No For the same reason as today? Yes No

Have you had previous plastic surgery? Yes No

Have you ever been treated with Accutane (Isotretinoin) or any other acne medication? Yes No

WOMEN ONLY:

IS THERE A CHANCE YOU COULD BE PREGNANT NOW? YES NO

NURSING ONLY: AGE: _____ HEIGHT: _____ WEIGHT: _____ T/P/R: _____ BP: _____



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PLASTIC SURGERY CENTER

Patient Name: _____

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Signed: _____ Print: _____ Date: _____

Office Witness: _____ Print: _____ Date: _____

IN ADDITION to use of these photographs for the purposes as previously stated, I consent to their use as specifically indicated below **(please check appropriate boxes to indicate approved choices):**

YES **NO**

My/my child's photographs may be used for the purpose of education or science, and as such may be published and republished with appropriate documentation in professional journals or medical books, or used for any other purpose which may be deemed proper in the interest of medical education, knowledge or research; provided however, that it is specifically understood that in such publication or use I shall not be identified by name.

YES **NO**

My/my child's photographs may be used for the purpose of patient/public education, and as such may be viewed by others. It is specifically understood that in such use of these photographs, I shall not be identified by name.

addendum _____

Signed: _____ Print: _____ Date: _____

Office Witness: _____ Print: _____ Date: _____



EAST LAKE
PLASTIC SURGERY CENTER

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

This notice describes how medical information about you may be used and disclosed and how you may get access to this information. Please review it carefully.

We Safeguard Information about Your Health and Person:

We collect information from you and store it in a medical record as well as on a computer. Charts are stored in a secure area and available only to a designated staff and only for designated reasons. Housekeeping, maintenance and other non-office personnel have no access to the chart area. Service technicians may have access to the computer, but only for service of computer operations.

Typical Uses and Disclosures of Medical Information:

We collect medical information from you. Within our office, we restrict the disclosure of the information to doctors, nurses, technicians and insurance and billing personnel. **We may use your medical information for treatment and care, payment to insurers and for healthcare operations.** Outside our office, we restrict the disclosure to those people, entities and agencies for whom you authorize disclosure such as other healthcare providers (doctors, nurses, extended care facilities), insurance companies, billing agencies, hospitals and surgery sites, or those agencies and entities for whom legal and administrative requirements demand disclosure such as:

- When required by law
- Public health activities (death, child abuse, neglect, domestic violence, problems with products, reactions to medications, product recalls, disease/infection exposure, disease/injury/disability control/prevention)
- Health oversight activities (audits, investigations, inspections)
- Judicial and administrative proceedings (court order)
- Appropriate law enforcement requests (to identify or locate a suspect, fugitive, material witness, or missing person)
- Deceased person information to coroners, medical examiners, funeral directors
- Organ and tissue donation
- Research, provided authorization is IRB-approved or privacy board-approved
- Emergencies or to avert serious threat to health or safety
- Specialized government functions (military, inmates)
- Workers Compensation
- Disaster Relief and Fund-raising

We will not use or disclose your medical information for any purpose not listed without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

Patient Privacy Rights

(Notice of Privacy Practices for Protected Health Information)

You Have The Right To:

- Inspect and request copies of your medical information from your chart. Your request must be submitted in writing to the contact person (Privacy Officer) listed at the end of this notice. Copies are subject to charges of \$1.00 per page for the first 25 pages. Each additional page in excess of the first 25 pages will be subject to charges of \$0.25 per page. Copies made for Workers Compensation will be subject to a charge of \$0.50 per page. Postage charges will apply if you request to have the copies mailed to you. We must respond within 30 days if the record is readily available and within 60 days if it is not readily available.
- Request that we amend medical information in your chart. You may identify inaccurate or incomplete information in your chart. Your request must be submitted in writing to the contact person (Privacy Officer) listed at the end of this notice. We must respond within 60 days. We may deny your request if we did not create the information you wanted changed or for certain other reasons. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable effort to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
- Receive an accounting of any disclosures made from your record over the last six years, starting April 14, 2003. You can get this with a written request directed to our office. We must respond within 60 days.
- Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
- Request that we communicate with you about your medical information by different means or to different locations. Your request must be made in writing to the contact person (Privacy Officer) listed at the end of this notice.
- Receive a copy of this notice by printing it or with a written request directed to this office, and a copy of this notice will be given with all new patient packets.

We may contact you for appointment reminders and we may provide you with information about health-related or product benefits and services.

Each patient is given a copy of the Privacy Notice and an opportunity to review and understand it.

Our Responsibility Under HIPAA:

- We are required by law to maintain the privacy of your personal health information, and to provide you notice of our legal duties and privacy practices and adhere to this notice.
- We reserve the right to make changes to this notice. If any changes are made, we will post a notice that changes have been made and their effective date of the changes. Copies will be made available.

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us. You can submit a complaint about our privacy policy or its execution, either verbally or in writing, to our **PRIVACY OFFICER** at: **East Lake Plastic Surgery Center**Isidoros Moraitis, M.D., P.A.** 3890 Tampa Road Suite 406**Palm Harbor, FL 34684**Phone: (727)-773-9796**Fax: (727)-773-9429**

If you get no resolution to your complaint, you may send a written statement to this office or the Secretary of Health and Human Services.

Effective Date Privacy Policy: April 14, 2003

Amended Dates:

THANK YOU FOR CHOOSING OUR PRACTICE!



Please take a moment to complete all information on this record. The information you provide is treated as confidential.

EAST LAKE
PLASTIC SURGERY CENTER

PATIENT HISTORY

Patient Name: _____ Account #: _____

Date: _____ Reason for your visit today: _____ Date of Injury, If Applicable: _____

Please list current medical conditions (Heart problems, diabetes, bleeding disorder, etc): _____

Medications currently taken on a regular basis (including over-the-counter and Herbals): _____

- HAVE YOU **EVER** HAD:
- | | | |
|--|---|--|
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> HIGH OR LOW BLOOD PRESSURE | <input type="checkbox"/> LIVER DISEASE |
| <input type="checkbox"/> LUNG PROBLEMS | <input type="checkbox"/> RHEUMATIC FEVER | <input type="checkbox"/> KIDNEY DISEASE |
| <input type="checkbox"/> SHORTNESS OF BREATH | <input type="checkbox"/> PAIN IN THE CHEST | <input type="checkbox"/> DIABETES/ INSULIN USE |
| <input type="checkbox"/> HEART MURMUR | <input type="checkbox"/> PAIN IN THE ARMS | <input type="checkbox"/> BLEEDING PROBLEMS |
| <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> DIZZINESS | <input type="checkbox"/> BREAST DISEASE |
| <input type="checkbox"/> HEART SURGERY | <input type="checkbox"/> CONVULSIONS | <input type="checkbox"/> GLAUCOMA |

- ARE YOU ALLERGIC TO:
- | | | |
|--|--|---|
| <input type="checkbox"/> FOODS _____ | <input type="checkbox"/> PENICILLIN | <input type="checkbox"/> DEMEROL |
| <input type="checkbox"/> SHELLFISH/ IODINE | <input type="checkbox"/> OTHER ANTIBIOTICS | <input type="checkbox"/> ANY ANESTHETIC _____ |
| <input type="checkbox"/> ASPIRIN | <input type="checkbox"/> CODEINE | <input type="checkbox"/> NOVOCAINE/LIDOCAINE |

Please list **any other allergies** not mentioned above: _____

Have you ever had a general anesthetic before? Yes No If Yes, for what? _____

Describe any problems you had with Anesthesia, if any: _____

Do you smoke? Yes No If yes, how often? _____ How many cigarettes per day? _____

Do you use any other tobacco products? Yes No If yes, how often? _____

Are you under the care of a physician at this time for any problem? Yes No If yes, please explain: _____

COSMETIC SURGERY/PROCEDURE PATIENTS ONLY:

Have you ever consulted a plastic surgeon? Yes No For the same reason as today? Yes No

Have you had previous plastic surgery? Yes No

Have you ever been treated with Accutane (Isotretinoin) or any other acne medication? Yes No

WOMEN ONLY:

IS THERE A CHANCE YOU COULD BE PREGNANT NOW? YES NO

NURSING ONLY: AGE: _____ HEIGHT: _____ WEIGHT: _____ T/P/R: _____ BP: _____

NURSING ONLY: AGE: _____ HEIGHT: _____ WEIGHT: _____ T/P/R: _____ BP: _____

WELCOME TO OUR PRACTICE!



Please take a moment to complete this form so we can better assist you with your health care needs.

EAST LAKE
PLASTIC SURGERY CENTER

PATIENT INFORMATION

Date: _____ Account # _____

Last Name _____ First Name: _____ MI: _____ SS #: _____

Sex: M F Age _____ Date of Birth _____ Marital Status: S M D W SEP

Parents' Names if Patient is a Minor: Mother: _____ Father: _____

Spouse or Partner's Name: _____

Mailing Address _____ City: _____ State: _____ Zip: _____

Phone # home: () _____ cell: () _____ E-Mail: _____

Occupation _____ Employer Name: _____ work#: () _____

If Student: Full-Time Part-Time Name of School: _____

Notify in Case of Emergency: _____ Relation: _____ Phone #: () _____

Primary Care Doctor: _____ Phone #: () _____

How did you here about us? CHECK ALL THAT APPLY ER Internet Yellow Pages Yellow Pages Local newspaper Other _____

Doctor _____ Name Patient _____ Name (Optional) Friend _____ Name (Optional)

CARRIER INFORMATION

Primary Insurance: _____

Carrier Address: _____ City: _____ State: _____ Zip: _____

Carrier Phone #: _____ Policy #: _____ Group #: _____

Name of Policy Holder if other than Patient: _____ Date of Birth: _____ SS#: _____

Relationship to Patient: _____

Secondary Insurance: _____

Carrier Address: _____ City: _____ State: _____ Zip: _____

Carrier Phone #: _____ Policy #: _____ Group #: _____

Name of Policy Holder if other than Patient: _____ Date of Birth: _____ SS#: _____

Relationship to Patient: _____

PERMISSION FOR TREATMENT

I hereby voluntarily consent to and authorize medical care/diagnostic treatment and /or minor surgical treatment by **ISIDOROS MORAITIS, MD** deemed advisable and necessary in the diagnosis and treatment of my condition. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office. I authorize the use and disclosure of any of my past/current medical records for treatment and healthcare operations.

Signed: _____ Print Name: _____ Date: _____

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I hereby assign all medical/diagnostic/surgical benefits payable for the services rendered, to include major medical benefits to which I am entitled, including Medicare, Private Insurance and other health plans to **ISIDOROS MORAITIS, MD, PA**. I hereby authorize said assignee to release to CMS/Insurance Carriers and it agents all information needed to determine these benefits or benefits related to services. I understand that any unpaid balance not covered by this policy will be payable by me. I understand and agree, regardless of my insurance status, that I am ultimately responsible for the balance of any professional services rendered. I understand that I am responsible for any charges incurred if my account is sent to a collection agency and for any returned checks. I understand that Medicare and/or other Insurance Carriers do not cover all office services/ procedures. I agree to take full responsibility for any unpaid balances and that such payment will be made to the said assignee for services.

Signed: _____ Print Name: _____ Date: _____

Office Witness: _____ Print Name: _____ Date: _____



EAST LAKE
PLASTIC SURGERY CENTER

PATIENT PRIVACY QUESTIONNAIRE

Patient Name: _____ Today's Date: _____ Account #: _____

Patient SS#: _____

1. Please list the family members or significant others, if any, whom we may inform about your medical condition and your diagnosis (including treatment, payment and health care operations) **and** In Case of an Emergency:

Name: _____ Relationship: _____
Address: _____ City: _____ State: _____ Zip: _____
SS#: _____ DOB: _____
Phone #: _____ (PLEASE \checkmark IF) IN CASE OF EMERGENCY ONLY

Name: _____ Relationship: _____
Address: _____ City: _____ State: _____ Zip: _____
SS#: _____ DOB: _____
Phone #: _____ (PLEASE \checkmark IF) IN CASE OF EMERGENCY ONLY

Name: _____ Relationship: _____
Address: _____ City: _____ State: _____ Zip: _____
SS#: _____ DOB: _____
Phone #: _____ (PLEASE \checkmark IF) IN CASE OF EMERGENCY ONLY

2. Please print the **address** of where you would like your Billing Statements and/or correspondence from our office to be sent: _____ City: _____ State: _____ Zip: _____
3. Please indicate whether or not you would **want to receive phone calls** about your appointment reminders, follow-ups, test results, etc. YES NO

Please print the **telephone number** where you want to receive calls about your appointments, follow-up, test results or other health care information: please circle: home/work/cell* _____
**I am fully aware that a cell phone is not a secure and private line.*

4. Can **appointment reminders** be left on you telephone answering machine or voice mail? YES NO
5. Can **other confidential messages** (lab results, etc.) be left on your telephone answering machine or voice mail? YES NO

If YES, please indicate what types of messages may be left on your machine?
 Lab Results X-Ray Results Follow-up Needed

Patient/Legal Guardian Signature: _____ Date: _____

Witness: _____ Date: _____



EAST LAKE
PLASTIC SURGERY CENTER

SKIN CARE SERVICES CLIENT INFORMATION

Date _____ Account # _____

Last Name _____ First Name: _____ MI: _____ SS #: _____
 Sex: M F Age _____ Date of Birth _____ Marital Status: S M D W SEP
 Parents' Names if Patient is a Minor: _____
 Mailing Address _____ City: _____ State: _____ Zip: _____
 Phone #: (home) _____ (work) _____ (cell) _____
 Occupation _____
 Notify in Case of Emergency: _____ Phone #: _____
 Primary Care Doctor: _____ Phone #: _____
 How did you here about us? _____

Microdermabrasion and **Chemical Peels** should be avoided in individuals with HIV, uncontrolled diabetes, suspected TB or who are pregnant/lactating or trying to become pregnant. Is there a possibility that you may have one of these conditions? Yes No

Have you had BOTOX® or Collagen injections within the last two (2) weeks? Yes No

Have you undergone Laser Resurfacing within the past twelve (12) weeks? Yes No

Have you had a glycolic, salicylic or TCA peel within the past eight (8) weeks? Yes No

Are you currently taking any of the following medications? Coumadin Accutane Aspirin

Have you ever experienced an allergic reaction to latex? Yes No

Are you experiencing any problems or concerns with the skin care program that you are currently following?
Yes No If yes, please explain: _____

PERMISSION FOR TREATMENT

I hereby voluntarily consent to and authorize medical care/diagnostic treatment and /or minor surgical treatment by **ISIDOROS MORAITIS, MD** deemed advisable and necessary in the diagnosis and treatment of my condition. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office. I authorize the use and disclosure of any of my past/current medical records for treatment and healthcare operations.

Signed: _____ Print Name: _____ Date: _____

Office Witness: _____ Print Name: _____ Date: _____



EAST LAKE
PLASTIC SURGERY CENTER

SKIN CARE EVALUATION

Date _____

Account # _____

1. Have you ever seen a dermatologist or plastic surgeon for your skin? YES NO
2. Are you currently under a physician's care? YES NO Reason: _____
3. Have you ever used Accutane? YES NO
4. Have you ever had a skin allergy? (i.e. cosmetics, fabrics, latex, salicylic, or glycolic acids, etc) YES NO
If yes, please explain: _____
5. Do you have any medication allergies? YES NO
If yes, please explain: _____
6. Are you pregnant, lactating or planning to become pregnant? YES NO
7. While pregnant, did you get hyperpigmentation or masking? YES NO
8. Are you going through menopause? YES NO
9. Do you wear contact lenses? YES NO
10. Do you exercise regularly? YES NO Do you take Vitamins? YES NO
11. Do you smoke? YES NO If not, were you ever a smoker? YES NO How long? _____
12. Do you have broken capillaries? YES NO If yes, please indicate where: _____
13. Do you have acne or periodic breakouts? YES NO
 Pimples Whiteheads Blackheads Enlarged Pores Flakiness Acne Scars
14. Do you have: Deep Wrinkles Crows Feet Fine Lines
15. Skin Type (Fitzpatrick Classification) Please circle the category that you feel best describes you
I- Always burn, never tan IV- Never burn, always tan
II- Always burn first, then tan V- Hispanic, Asian, Mediterranean, Middle Eastern
III- Sometimes burn, sometimes tan VI- Black
16. What percentage of time do you spend in the sun? Summer _____% Winter _____%
17. Do you use a sunblock when outdoors? YES NO What SPF do you use? _____
18. Do you use chemical self-tanning lotions? YES NO Tanning beds? YES NO
19. Have you or members of your family had skin cancer? YES NO Location: _____
20. Do you form thick or raised scars from a cut or burn? YES NO
21. Current hair removal treatment: Bleach Electrolysis Wax Pluck Shave
22. How sensitive is your skin? _____
23. Do you or have you ever had any of the following:
 Keloid scarring Hepatitis Dermatitis Excema Acne scarring Herpes Simplex
 Skin Cancer HIV+ Other (please specify) _____
24. Have you ever had any of the following treatments: Chemical Peel Glycolic Peel Laser Peel
 Collagen Botox Cosmetic surgery Other (please specify) _____
25. What products are you presently using? _____
26. Do you use or have you ever used any of the following products? If so, when?
 Retin-A Retinol AHA Hydroquinone Accutane Renova
 Metrogel Differin BCP Other _____
27. Which conditions would you like to improve? Hyperpigmentation Sun Damage Acne scarring
 Age spots Fine lines and wrinkles Acne # of months ___ years _____ Surgical/Facial scars
 Enlarged pores Stretch marks Other (please specify) _____
28. Areas to be treated: (Please detail entry) _____

