Anthony N. Dardano, D.O., P.A., F.A.C.S.

AESTHETIC AND RECONSTRUCTIVE PLASTIC SURGERY

Diplomate of the American Board of Plastic Surgery
Diplomate of the American Board of Surgery
951 N.W. 13th Street, Suite 4D
Tel: (561) 361-0065 Fax: (561) 347-1945

PATIENT REGISTRATION

Must complete entirely

Today's Date: _____ How did you hear about Dr. Dardano?_____

Reason for today's visit: _____

New Patient: Y N Existing Patient: Y N

Cosmetic Consult: Y N Surgical Follow up: Y N Emergency Room Follow up: Y N

Patient Name: _____Date of Birth: _____ Age: _____

Social Security #: _____ Sex: _____ Marital Status: S M D

Permanent full Address: _____

City:_____ State:_____ ZIP:_____

Home Phone #: _____Cell #: _____ Work Phone #: _____

Spouse or Parent Name: _____ Emergency Contact #: _____

E-Mail address:_____

INSURANCE and or PAYMENT INFORMATION

Medicare _____HMO _____PPO _____Auto _____Worker's Comp _____ Cosmetic _____Self Pay_____

ID #: _____ Group #: _____

Insurance Company Name: _____ Phone #: _____

Name of Insured: _____ Date of Birth: _____ Social Security # _ _____

Secondary Insurance Company: _____ Phone #: _____

Secondary Insurance Address: _____

ID#: _____ Group #: _____

Name of Insured: _____ Date of Birth: _____ Social Security # _____

"**Under Florida law, osteopathic physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. YOUR OSTEOPATHIC PHYSICIAN HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law subject to certain conditions. Florida law imposes strict penalties against noninsured osteopathic physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law."**

I certify the above information is true and correct to the best of my knowledge. I have read and understand the above statement, and I agree to notify you of any changes in my health status or the above information.

Patient Signature/Parent Signature: _____

PATIENT SOCIAL HISTORY

Type of Employment _____

Do you smoke? **Y N** Do you consume alcoholic beverages? **Y N** Have you ever used street drugs? **Y N**

MEDICAL HISTORY (PLEASE MAKE SURE ALL MEDICAL HISTORY IS FILLED OUT)

Current Primary Physician:_____ Phone No:_____

Height _____ Weight _____

Do you have a removable dental appliance or dentures? _____ Caps____ Bridges ____ Loose teeth_____

Women: How many times were you pregnant? _____How many children do you have?_____

Medication Allergies: _____

Current Medications: _____

_____

Prior Surgeries: _____

Medical Conditions:_____

_____

FAMILY HISTORY

Cancer _____ Heart Disease _____ Diabetes _____ Other _____

Bleeding Disorders _____ Allergies or Reaction to anesthesia _____

REVIEW OF SYSTEMS

Check all that apply:

_____ Breathing Problems
_____ Persistent Cough, Blood (TB)
_____ High Blood Pressure
_____ Heart Problems
_____ Stroke, Numbness, Weakness in arms/legs
_____ Fainting Spells, Thyroid Disorder
_____ Hiatal Hernia, Gallbladder, Stomach
_____ Hepatitis, Liver Disease
_____ Kidney Stones
_____ Diabetes, hypoglycemia
_____ Cancer, Tumors (types?) _____
_____ Emotional/Psychiatric Illness
_____ Sexually Transmitted Diseases
_____ HIV
_____ Pancreatic Disorders
_____ Arthritis

In addition to the above mentioned, are there any other conditions Dr. Dardano should know about? Please Explain:

_____

_____

Release & Assignment: I hereby authorize Anthony N. Dardano, D.O. ,P.A. to release to your company or its representative, any and all information including the diagnosis and records of any treatment or examination rendered to me during the period of such Plastic Surgical care. I also authorize and request your company to pay directly the above named physician the amount due to me in my pending claim for Basic Medical, Major Medical and/or Surgical treatment or services, by reason of such treatment or services rendered.

Patient Signature: _____ **Print Name:** _____

Date: _____

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Tel: (561) 361-0065 Fax: (561) 347-1945

FINANCIAL POLICY

(Please Read Carefully)

Payment is required at the time of service. We accept cash, personal check or credit card.

AESTHETIC (COSMETIC) SURGERY

Since these procedures are not covered by insurance, Aesthetic (cosmetic) surgery is always prepaid, in full, two weeks prior to surgery.

PERSONAL HEALTH INSURANCE

Every attempt will be made to help you so that you are reimbursed by your insurance carrier for the surgical fee and any payments that are due on office visits. However, please remember an insurance contract is made between the patient and the insurance carrier and not the physician. The amount paid by the insurance carrier is specified in your contract and mayor may not be the same as the value of the physician's services. The ultimate obligation for payment of services rests with the patient. Even though an insurance claim may be filed, you (the patient) are responsible for the total amount due. This office cannot accept responsibility for collecting your insurance claim or for negotiating its settlement.

MEDICARE

If you are a Medicare patient, please verify that we have all of the correct information regarding your Medicare coverage. If you have a supplement that is not a Medigap policy, you will be responsible for co-payments at the time of visit. You are responsible for all deductibles, co-payments and any procedure deemed not medically necessary by Medicare.

WORKERS' COMPENSATION

If you are being seen for a Workers' Compensation injury you will be required to provide us with the employer, phone number and contact person or adjuster, so that we may verify coverage and obtain authorization for treatment. If this is an emergency and we are unable to obtain authorization prior to treatment, the patient will be entirely responsible for all fees until treatment has been authorized. If possible please provide us with a First Notice of Injury, supplied by your carrier.

COLLECTION FEES

If your account falls delinquent, we reserve the right to charge interest not to exceed 1.5 monthly. If collection proceedings should occur, the patient assumes the responsibility of collection and attorney fees. I agree to protect Dr. Dardano's fees in case of payments received as a result of legal settlements.

I HAVE READ THE FINANCIAL POLICY STATED HEREIN AND AGREE TO THE TERMS AS STATED.

_____ _____

Responsible Party/Patient Date

NOTICE OF SELF INSURANCE

Society has forced the practice of medicine to become more like a business rather than a medical profession. Due to the rising costs and lack of insurance carriers, I have been forced to make a business decision not to purchase medical malpractice insurance. I am required by Florida Statute 458.320 to inform you with the following statement…

"Under Florida law, osteopathic physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. YOUR OSTEOPATHIC PHYSICIAN HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law subject to certain conditions. Florida law imposes strict penalties against noninsured osteopathic physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law."

Signed_____ Date_____

Anthony N. Dardano, D.O., F.A.C.S.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
YOU MAY REFUSE TO SIGN THIS ACKNOLEDGEMENT

I, _____, have received a copy of this office's Notice of Privacy Practices.

Name: _____
Signature: _____
Date: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledge of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

____ Individual refused to sign
____ Communication barriers prohibited obtaining the acknowledgement
____ An emergency situation prevented us from obtaining acknowledgement
____ Other _____