**RICHARD A. D'AMICO, M.D.** **DATE**_____

CONFIDENTIAL PATIENT INFORMATION
(complete all items, please print)

PATIENT'S NAME_____
(LAST) (FIRST) (MI)
PATIENT'S SS#_____E-MAIL ADDRESS_____

HOME ADDRESS_____CITY_____ST_____ZIP_____

HOME PHONE#_____BUSINESS PHONE#_____EXT._____CELL:_____

BIRTHDATE_____ AGE_____ MALE_____FEMALE_____

EMPLOYER:_____

EMPLOYER'S ADDRESS:_____

OCCUPATION:_____

MARRIED_____ SINGLE_____ WIDOWED_____ DIVORCED_____ SEPARATED_____

NAME OF SPOUSE **or legal guardian** if **minor**)_____

SPOUSE OR GUARDIAN'S EMPLOYER_____
ADDRESS_____

NEAREST RELATIVE AND ADDRESS:_____

**PATIENT REFERRED BY:** _____
__ ASAPS __ ASPS __ IMPLANT INFO.COM __ NY MAGAZINE TOP DOC __ OTHER_____

HAS DR. D'AMICO CONSULTED OR TREATED ANY FAMILY MEMBER?_____
IF YES, WHOM?_____

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**SPECIFIC PROBLEM FOR WHICH YOU ARE SEEKING PLASTIC SURGERY**:

_____

HAVE YOU CONSULTED OTHER PHYSICIANS INCLUDING PLASTIC SURGEONS ABOUT THIS? _____
IF YES, DOCTOR'S NAME_____

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**INSURANCE INFORMATION**

NAME OF INSURED_____SS#_____DOB_____

INSURANCE COMPANY_____TELEPHONE #_____

ADDRESS_____

ID#_____POLICY #_____GRP#_____CO-PAY_____

IF GROUP INSURANCE, COMPANY NAME OF EMPLOYER_____

**PERSON FINANCIALLY RESPONSIBLE**: Patient ( ) Parent ( ) Other ( ) Relationship_____SS#_____

NAME_____DOB_____Telephone #_____
(party financially responsible )
ADDRESS _____
EMPLOYER_____Telephone #_____
EMPLOYER'S ADDRESS_____

_____

**PAST MEDICAL HISTORY**

GENERAL HEALTH: GOOD ____ FAIR ____ POOR____ IF NOT "GOOD", PLEASE EXPLAIN:

HEIGHT_____WEIGHT____WEIGHT LOSS/GAIN IN PAST YEAR_____LBS LOSS GAIN

NAMES ADDRESSES AND TELEPHONE NUMBERS OF TREATING PHYSICIANS:

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

WHEN WAS YOUR LAST MAMMOGRAM?_____

HOW LONG AGO WAS YOUR MOST RECENT PHYSICAL CHECK-UP?_____
DID IT INCLUDE AN ELECTROCARDIOGRAM? NO____ YES____
CHEST X-RAY? NO__YES___

HAVE YOU EVER HAD AN ECHOCARDIOGRAM? NO_____YES_____
A CARDIAC ULTRASOUND? NO _____ YES _____
A STRESS TEST? NO _____ YES _____

ARE YOU, OR COULD YOU BE, PREGNANT?_____
WHEN WAS THE DATE OF YOUR LAST MENSTRUAL PERIOD? _____

**SERIOUS ILLNESSES** (Please list)_____
_____

Have you had any illnesses or disorders of the following? (Circle if YES)

| | | | |
|---|---|---|---|
| FACE (paralysis, stroke, epilepsy) | HEART or BLOOD VESSELS (MPV, heart valve, scarlet/rheumatic fever) | BLOOD DISORDERS | HIGH BLOOD PRESSURE |
| BRAIN | NERVOUS SYSTEM (paralysis, numbness) | EAR, NOSE, SINUS, THROAT | STOMACH |
| URINARY SYSTEM | BONES or JOINTS | EYES (glaucoma, dryness) | BREASTS |
| INTESTINES | REPRODUCTIVE SYSTEM | ENDOCRINE SYSTEM or DIABETES | LUNGS (asthma) |
| LIVER (hepatitis) | ARMS or LEGS | | |

If circled, please explain:_____
_____

**MALIGNANT HYPERTHERMIA SCREENING**

a family history of deaths following general anesthesia or exercise?_____No__ Yes__
a family or personal history of Malignant Hyperthermia?_____No__ Yes__
muscle or neuromuscular disorder?_____No__ Yes__
a personal history of muscle spasm?_____No__ Yes__
dark or chocolate-colored urine?_____No__ Yes__
unanticipated fever immediately following anesthesia or serious exercise?_____No__ Yes__

**BLEEDING/CLOTTING HISTORY**

Have you had any bleeding or clotting disorders? (e.g. Thrombosis, pulmonary emboli?) Yes___ No___
Do you bruise spontaneously? Yes___ No___
Have you ever been told by a doctor that you have a bleeding or bruising problem? Yes___ No___

**PREVIOUS SURGERY (Please list)**

Operations Year Hospital City Surgeon's Names Anesthesia(Local or General)

_____
_____
_____
_____
_____

HAVE YOU HAD SIGNIFICANT COMPLICATIONS OR AFTER EFFECTS FROM ANY OF THESE OPERATIONS? NO____ YES ____

IF "YES", PLEASE EXPLAIN_____

_____
_____

**INJURIES**

Type Year Hospital Doctor After-Effects

_____
_____

**FAMILY HISTORY**

| | Age | State of Health |
|---|---|---|
| Mother | | |
| Father | | |
| Brother(s) | | |
| Sister(s) | | |
| Children | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Has any relative had:

Cancer……No___Yes___
Diabetes……..No___Yes___
Heart Disease……..No___Yes___
High Blood Pressure……No___Yes___
Lung Disease……..No___Yes___
Blood or Bleeding Disorders……..No___Yes___
Asthma……No___Yes___
Mental Illness……No___Yes___
Muscular Dystrophy……No___Yes___
Malignant Hyperthermia……No___Yes___

**MEDICATIONS, DRUGS**

What is your approximate daily consumption of the following:

Coffee or Tea_____Alcohol_____Tobacco_____

Other intoxicating or mind altering drugs (specify)_____

Does anyone else in your household smoke? No____Yes____How much?_____

PLEASE LIST ALL YOUR MEDICATIONS AND THEIR DOSAGES (INCLUDING BIRTH CONTROL PILLS, DIURETICS (WATER PILLS) BLOOD PRESSURE OR HEART MEDICATIONS, TRANQUILIZERS, HORMONES, BLOOD THINNERS, NOSE DROPS AND SPRAYS, INHALER MEDICINES, RUB-ON MEDICATIONS (LINIMENTS), ASPIRIN, BUFFERIN, ETC.):

_____
_____

**PERTINENT PREOPERATIVE INFORMATION**

Are you allergic to any medications? No_____ Yes_____
If "Yes", which one(s)?_____

Do you have any food allergies? No_____Yes_____
If "Yes", which one(s)? _____

Have you ever reacted badly to being put to sleep for surgery? _____No__Yes__

Has any member of your family ever reacted badly to being put to sleep for surgery?_____No__Yes__

Have your required unusually large amounts of local anesthetic for medical/dental procedures? No__Yes__

Have you ever had a bad reaction to a local anesthetic (Novocain, etc.)?_____No__Yes__

Are you allergic to adhesive tape?_____No__Yes__

Are you allergic to suture material such as catgut?_____No__Yes__

Are you a slow or poor healer?_____No__Yes__

Do you form large scars or keloids?_____No__Yes__

Do you have skin diseases, hives, eczema or rash?_____No__Yes__

Do you have frequent infections or boils?_____No__Yes__

Have you taken steroid medications, cortisone or ACTH? If so, how long ago?_____No__Yes__

Have you taken Accutane?_____When?_____No__Yes__

Have you ever been on Phen Phen, ephedrine or other weight loss reduction products? No__Yes__

Do you have shortness of breath with walking?_____No__Yes__

Do you have, or have you had, any back trouble?_____No__Yes__

Have you ever been tested for HIV(AIDS)? If yes, positive or negative?_____No__Yes__

Have you ever tested positive for Hepatitis?___(A, B, or C) _____No__Yes__

Have you ever had an outbreak of Herpes?_____No__Yes__

Does your religion prohibit blood transfusions?_____No__Yes__

Do you have, or have you had, any significant emotional problems?_____No__Yes__

Have you ever had, currently in, or been advised to seek psychotherapy or psychiatric care? No__Yes__

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Signature_____Relationship to Patient_____

PRINT NAME_____ Date: _____

**RICHARD A. D'AMICO, MD, PA**

**PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

I hereby give my consent for Richard A. D'Amico, MD, PA, to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).
Richard A. D'Amico's Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent.

Richard A. D'Amico, MD, PA reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Richard A. D'Amico, MD, PA Privacy Officer at 180 North Dean Street, Englewood, NJ 07631.

With this consent, Richard A. D'Amico, MD, PA may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Richard A. D'Amico, MD, PA may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as consent forms, instructions for surgery, paperwork that may mention diagnosis and procedures, appointment reminder cards and patient statements/receipts as long as they are marked Personal and Confidential.

With this consent, Richard A. D'Amico, MD, PA may e-mail &/or fax[1] to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Richard A. D'Amico, MD, PA, restrict how it uses or discloses my PHI to carry out TPO. *However, the practice is not required to agree to my requested restrictions*, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Richard A. D'Amico's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Richard A. D'Amico, MD may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Patient's Name Date

_____
Print Name of Patient or Legal Guardian

Richard A. D'Amico, MD, FACS
Plastic and Reconstructive Surgery
180 North Dean Street
Englewood, NJ 07631

Phone: (201)-567-9595
Fax: (201)-567-1813

**OFFICE POLICIES:**

We are committed to providing you with the best possible care. If you have insurance, we are anxious to help you receive your maximum allowable benefit. In order to achieve these goals, we need your assistance and your understanding of our payment policy. Payment is due at the time services are rendered. **For your convenience, we accept Visa and Master Card.

**My payment for today will be by: _____check _____cash _____charge**

**Returned checks are subject to a $20.00 service charge.
**Balances older than 30 days will be subject to annual interest charges of 8% unless prior arrangements have been made.
**A $50.00 service charge will be added to my bill if I fail to pay my insurance co-payment. I understand that if I fail to keep any financial agreement I make with this practice, and my account must be sent to a collection agency, I will be responsible for **ALL** collection costs and legal fees incurred.
**If payment for procedure or office visit is made with a credit card, it is non-refundable.

IF YOUR INSURANCE COMPANY REQUIRES A REFERRAL, IT IS YOUR RESPONSIBILITY TO HAVE A VALID REFERRAL AT THE TIME OF YOUR VISIT. IF YOU DO NOT HAVE A VALID REFERRAL AND STILL WISH TO BE SEEN BY THE DOCTOR, YOU WILL BE EXPECTED TO PAY PRIOR TO SEEING THE DOCTOR. YOU ARE RESPONSIBLE FOR ANY AND ALL FEES ASSOCIATED WITH THAT VISIT.

PAYMENT/INSURANCE POLICIES FOR SURGERY:

Every insurance company has their own criteria for "cosmetic "or "not medically necessary". To our knowledge, there are no plans that will pay for the removal of uninflamed, asymptomatic skin tags, seborrheic keratoses, and milia. While we are happy to provide such treatments, at your request, you will be expected to pay for such services at the time of treatment and NO insurance claims will be submitted for these services. For procedures such as excision of benign cysts, benign skin lesions, the repair of torn earlobes, scar revisions and other procedures that insurance companies have increasingly been denying, you will be expected to pay at the time of service and a claim will be submitted for you.

Signature Date

# Richard A. D'Amico, MD, FACS

Plastic and Reconstructive Surgery
180 North Dean Street
Englewood, NJ 07631
(201) 567-9595
FAX: (201) 567-1813


**SIGNATURE ON FILE:**

I authorize use of this form on all my insurance submissions, permitting a copy of this to be used in place of the original, and further authorizing Dr. D'Amico to act as my agent in helping me obtain payment from my insurance companies. I authorize release of information to all my insurance companies.

I authorize direct payment to Dr. D'Amico.

I understand that it is my responsibility to notify Dr. D'Amico's office of any change in my insurance plan, coverage or claim address since my last visit. Failure to do this could result in a denial for "timely filing" and I would then be responsible for any and all fees from that date and beyond.

_____ _____

Signature of patient or responsible party for minor

Date

**E-MAIL & FAX AUTHORIZATION:**

I authorize Dr. D'Amico to reach me at the following:

**E-MAIL:**_____ **FAX:** _____

# Richard A. D'Amico, MD, FACS

Plastic and Reconstructive Surgery
180 North Dean Street
Englewood, NJ 07631
201-567-9595
FAX: 201-567-1813


## SURGICAL CANCELLATION POLICY:

Should the patient cancel the planned surgery, the following reimbursement schedule will apply:

- Two weeks or greater prior to surgery, 35% of the surgical fee will be retained.
- One week or less prior to the surgery, 50% of the surgical fee will be retained.

If cancellation of your surgery is due to illness, you must obtain a note from your physician stating that a valid illness is the reason for your cancellation. A segment of this deposit is a non-refundable processing fee of $750.00.
I have read and understand the information outlined above.

_____ _____
Patient's signature or guardian if minor Date:

## DISCLAIMER:

Professional fees are paid for professional services rendered (e.g. surgery, anesthesia, etc.) and not for results or outcomes. Dr. D'Amico reserves the right to charge for revisional surgery or for further surgery necessary to achieve the patient's goals. From time to time, under special circumstances, consideration may be given for partial or complete refunds. This will be at Dr. D'Amico's sole discretion.

## CREDIT CARD PAYMENT DISCLAIMER NOTICE

I the undersigned wish to pay for professional services rendered by Richard A. D'Amico, MD, using my credit card. I understand that such payment is for the rendering of professional services. No representation is made for the outcome or results of such professional services, including surgery. Payment is made entirely for the performance and rendering of the services and once those services are rendered I understand I waive my rights to recourse with Dr. D'Amico or with the credit card company regardless of my level of satisfaction with services rendered.

_____
Patient Signature or guardian if minor

_____
Witness

_____
Date