PIAZZA CENTER FOR PLASTIC SURGERY AND ADVANCED SKIN CARE

7900 FM 1826, Health Plaza II, Suite 206, Austin, TX 78737
P: 512.288.8200 F: 512.288.8207
www.thepiazzacenter.com

Patient Information

Name: _____ _____ DOB: _____ Sex: F M
Last **First** **MI**

Marital Status: S M P D W Ethnicity: _____ Race: _____ Religion: _____ Language: _____

Social Security #: _____ Drivers License #: _____ State: _____

Mailing Address: _____
City **State** **Zip Code**

Street Address: _____ Email Address: _____
(if different than mailing)

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer: _____ Occupation: _____

Employer's Address: _____

Spouse / Parent / Responsible Party: _____ DOB: _____ SS#: _____

Mailing Address: _____
City **State** **Zip Code**

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Primary Care Physician: _____ Phone: _____

INSURANCE INFORMATION

Primary Insurance: _____

Subscriber Name: _____ DOB: _____ SS#: _____

Subscriber ID#: _____ Group #: _____

Secondary Insurance (if applicable): _____

Subscriber Name: _____ DOB: _____ SS#: _____

Subscriber ID #: _____ Group #: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Referred By: Friend / Patient / Family member: _____

Doctor: _____ Hospital: _____

Internet Source: _____ Flyer / Brochure: _____

Company: _____ Other: _____

I verify that the above information is true and correct and that I will keep The Piazza Center informed of any changes in the above.

Signature (responsible party): _____ Date: _____

Signatures on this page expire one year from date signed. A new signature is required yearly.

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FINANCIAL & PROTECTED HEALTH INFORMATION

Name: _____ DOB: _____
Last First MI

Please review the following policies and acknowledge receipt by your signature.

Charges

- Cosmetic office charges require payment in full at the time of your office visit.
- Cosmetic surgical charges require deposits and payment in full in advance of surgical procedures.
- Insurance based visits require copay and /or deductible in full at the time of your visit.
- Charges related to an auto accident or third party injury require payment in full at **each** visit.

Insurance Billing

- It is your responsibility to provide us with correct insurance information for billing purposes.
- All balances not paid by your insurance and deemed patient responsibility are due upon receipt of bill from The Piazza Center.
- We will bill your insurance for **non-cosmetic** surgical procedures but may require deductible and coinsurance be paid prior to your surgery.
- It is your responsibility to respond to all requests for information you receive from your insurance company.

Overdue Accounts

- If your account has an amount due now, it is your responsibility to pay the balance timely.
- Accounts may be assessed a late fee if not paid within 30 days of receipt of statement.
- Accounts with a patient balance that are not paid within 90 days may be turned over to an outside collection agency. This action may affect your credit rating.
- Accounts referred to an outside collection agency may be charged the cost of collection fees and/or attorney fees.

Authorization and Release

I have read and understand the information above. I understand that I am financially responsible for all charges not paid and/or discounted by my insurance company. I hereby assign to the physician, payments for medical services rendered to myself or my dependents.

Signature: _____ Date: _____
Patient / Responsible party

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

- I hereby acknowledge that I have been offered, received or viewed a copy of The Piazza Center (TPC) Notice of Privacy Practices (NPP).
- With my consent, TPC may use and disclose protected health information about me to carry out treatment, payment and healthcare operations as discussed in the NPP.
- I may revoke my consent in writing except to the extent that the practice has already made disclosures relying upon my prior consent. If I do not sign this consent, TPC may decline to provide treatment.

Signature: _____ Date: _____
Patient / Responsible party

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For Clinic Use

_____Patient refused to sign Patient unable to sign because _____

Employee Signature: _____ Date: _____

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Consent to Communicate

Patient Name: _____ DOB: _____

Please mark the ways that you consent to us communicating with you

Method	Ok to Leave Voicemail	Ok to Leave Message with Another Person	Best Time to Call Please circle
☐ Call Work Phone	☐Yes ☐No	☐Yes ☐No	Any Morning Afternoon Evening
☐ Call Cell Phone	☐Yes ☐No	☐Yes ☐No	Any Morning Afternoon Evening
☐ Call Home Phone	☐Yes ☐No	☐Yes ☐No	Any Morning Afternoon Evening
☐ Send Email			
☒ Email Appointment Reminders are sent automatically			
☐ Email Medical Info			
Specials, discounts & upcoming events planned at PIAZZA will be emailed to you unless you select ☐ No			
☐ Send Regular Mail			
Mail to which Address: ☐ Home ☐ Other (please list):			
☐ Send Text Page			
☐ Text Appt Reminders – if so, list cell carrier:			
☐ Text Marketing Info – if so, list cell carrier:			

Please indicate person(s) authorized for messages and/or records below.

Name	DOB	Relationship	OK to Release Results	Any Comments
			☐Yes ☐No	
			☐Yes ☐No	
			☐Yes ☐No	

Signature: _____ Date: _____

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Medical Questionnaire

Patient Name: _____ **DOB:** _____

Allergies to Medications? ☐ No ☐ Yes-_____

List Current Medications: _____

Height: _____ Weight: _____

Dominant hand: ☐ Left ☐ Right ☐ Both

Marital Status:

☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Partner

☐ Spouse / Sig. Other Name: _____

☐ Children-Ages: _____

Social History	**Yes**	**No**
Do you currently smoke?	☐	☐
Have you ever used tobacco products?	☐	☐
How many packs per day? _____ How many years? _____		
Do you use alcohol?	☐	☐
Amount per week: _____		
Have you ever been treated for drug/alcohol problems?	☐	☐
Do you drink caffeinated beverages? (coffee, tea, pop)	☐	☐
How many per day: _____		
Do you feel safe where you are living now?	☐	☐
If no, do you want to talk to someone about this?	☐	☐

Past Medical History / Medical Problems (INCLUDE DATES)

_____

_____

_____

Prior Operations / Surgeries (INCLUDE DATES)

_____

_____

_____

Review of General Systems

Have you ever been diagnosed as having the following illnesses, or as having any of the following symptoms? If yes, state year.

Unusual fatigue	☐ Yes	Yr _____	☐ No	
Unexplained change in weight	☐ Yes	Yr _____	☐ No	
Recurrent fevers, chills, sweats	☐ Yes	Yr _____	☐ No	
Increased thirst	☐ Yes	Yr _____	☐ No	
Intolerance of heat or cold	☐ Yes	Yr _____	☐ No	
Decreased appetite	☐ Yes	Yr _____	☐ No	
Excessive thirst or appetite	☐ Yes	Yr _____	☐ No	
Cancer	☐ Yes	Yr _____	☐ No	
Eyes	☐ **No Concerns**			
Vision changes	☐ Yes	Yr _____	☐ No	
Pain / itching / drainage	☐ Yes	Yr _____	☐ No	
Glaucoma	☐ Yes	Yr _____	☐ No	
Integumentary	☐ **No Concerns**			
Rash	☐ Yes	Yr _____	☐ No	
Itching	☐ Yes	Yr _____	☐ No	
Ulcers / Wounds	☐ Yes	Yr _____	☐ No	

Review of Systems (Continued)

Ears, Nose and Throat	☐ **No Concerns**			
Sinus congestion	☐ Yes	Yr _____	☐ No	
Sneezing	☐ Yes	Yr _____	☐ No	
Hearing problems	☐ Yes	Yr _____	☐ No	
Difficulty swallowing	☐ Yes	Yr _____	☐ No	
Persistent sore throats	☐ Yes	Yr _____	☐ No	
Cardiovascular	☐ **No Concerns**			
High blood pressure	☐ Yes	Yr _____	☐ No	
Low blood pressure	☐ Yes	Yr _____	☐ No	
Heart attack	☐ Yes	Yr _____	☐ No	
Chest pain	☐ Yes	Yr _____	☐ No	
Racing heart	☐ Yes	Yr _____	☐ No	
Shortness of breath at night	☐ Yes	Yr _____	☐ No	
Swollen feet	☐ Yes	Yr _____	☐ No	
Heart murmur	☐ Yes	Yr _____	☐ No	
Leg cramps while walking	☐ Yes	Yr _____	☐ No	
High cholesterol	☐ Yes	Yr _____	☐ No	
Anemia	☐ Yes	Yr _____	☐ No	
Rheumatic fever	☐ Yes	Yr _____	☐ No	
Sickle cell disease	☐ Yes	Yr _____	☐ No	
Blood transfusions and year	☐ Yes	Yr _____	☐ No	
Any heart disease	☐ Yes	Yr _____	☐ No	
Respiratory	☐ **No Concerns**			
Shortness of breath	☐ Yes	Yr _____	☐ No	
Cough	☐ Yes	Yr _____	☐ No	
Coughing up phlegm / blood	☐ Yes	Yr _____	☐ No	
Frequent chest colds	☐ Yes	Yr _____	☐ No	
Wheezing, difficulty breathing	☐ Yes	Yr _____	☐ No	
Asthma/Bronchitis/Emphysema	☐ Yes	Yr _____	☐ No	
Gastrointestinal	☐ **No Concerns**			
Difficulty swallowing	☐ Yes	Yr _____	☐ No	
Heartburn	☐ Yes	Yr _____	☐ No	
Bloating	☐ Yes	Yr _____	☐ No	
Abdominal pain	☐ Yes	Yr _____	☐ No	
Nausea / Vomiting	☐ Yes	Yr _____	☐ No	
Ulcer	☐ Yes	Yr _____	☐ No	
Hernia	☐ Yes	Yr _____	☐ No	
Diarrhea	☐ Yes	Yr _____	☐ No	
Constipation	☐ Yes	Yr _____	☐ No	
Laxative use	☐ Yes	Yr _____	☐ No	
Black / Bloody stools	☐ Yes	Yr _____	☐ No	
Liver disease / Hepatitis	☐ Yes	Yr _____	☐ No	
Weight loss, how much?	☐ Yes	Yr _____	☐ No	
Neurological	☐ **No Concerns**			
Headaches	☐ Yes	Yr _____	☐ No	
Frequency	☐ Yes	Yr _____	☐ No	
Numbness	☐ Yes	Yr _____	☐ No	
Tremors	☐ Yes	Yr _____	☐ No	
Sleep problems	☐ Yes	Yr _____	☐ No	
Seizures / Stroke	☐ Yes	Yr _____	☐ No	
Depression/Anxiety/Mood Changes	☐ Yes	Yr _____	☐ No	

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Patient Name: _____

Genitourinary ☐ No Concerns
- Flank pain ☐ Yes Yr____ ☐ No
- Pain during urination ☐ Yes Yr____ ☐ No
- Incontinence (loss of urine) ☐ Yes Yr____ ☐ No
- Frequent bladder infections ☐ Yes Yr____ ☐ No
- Kidney disease ☐ Yes Yr____ ☐ No

Screenings ☐ No Concerns
- Last menstrual period _____ ☐ N/A
- Last PAP _____ ☐ N/A
- Last mammogram _____ ☐ N/A
- Last prostate exam _____ ☐ N/A
- Have you been tested for STDs ☐ Yes Yr____ ☐ No
- Have you been tested for HIV/AIDS ☐ Yes Yr____ ☐ No

Musculoskeletal ☐ No Concerns
- Back / Neck pain ☐ Yes Yr____ ☐ No
- Extremity/Joint pain/swelling/stiffness ☐ Yes Yr____ ☐ No
- Limitations of physical activity ☐ Yes Yr____ ☐ No

Endocrine / Metabolic ☐ No Concerns
- Diabetes Type I ☐ Yes Yr____ ☐ No
- Diabetes Type II ☐ Yes Yr____ ☐ No
- Currently on insulin? ☐ Yes Yr____ ☐ No
- Thyroid disease ☐ Yes Yr____ ☐ No

Heme / Lymph ☐ No Concerns
- Anemia ☐ Yes Yr____ ☐ No
- Bleeding tendency ☐ Yes Yr____ ☐ No
- Bruising ☐ Yes Yr____ ☐ No
- Swollen glands ☐ Yes Yr____ ☐ No
- History of clots in legs or arms ☐ Yes Yr____ ☐ No
- Swelling / fluid retention in arms or legs ☐ Yes Yr____ ☐ No

Family History ☐ No Concerns
- Is your mother living? ☐ Yes ☐ No, cause of death and age: _____
- Is your father living? ☐ Yes ☐ No, cause of death and age: _____
- Family history of breast cancer? ☐ Yes ☐ No – who: _____
- Family history of ovarian cancer? ☐ Yes ☐ No – who: _____
- Family history of heart disease? ☐ Yes ☐ No – who: _____
- Family history of diabetes? ☐ Yes ☐ No – who: _____
- Family history of hypertension? ☐ Yes ☐ No – who: _____

Is there anything else that you would like us to know so that we might better meet your needs?

_____

_____

Preferred methods of learning? ☐ Verbal ☐ Visual / Pictorial ☐ Demonstration ☐ Written

Barriers to learning:
- Hearing ☐ Yes ☐ No _____
- Vision ☐ Yes ☐ No _____
- Speech ☐ Yes ☐ No _____
- Language/Cultural/Religious ☐ Yes ☐ No _____
- Physical/Cognitive limitations ☐ Yes ☐ No _____
- Psych-social / Stress ☐ Yes ☐ No _____

Are you currently taking any of the following blood-thinning medications?
- Aspirin? ☐ No ☐ Yes, Last does when? _____
- Plavix? ☐ No ☐ Yes, Last does when? _____
- Coumadin? ☐ No ☐ Yes, Last does when? _____
- Warfarin? ☐ No ☐ Yes, Last does when? _____
- Ibuprofen / NSAIDs? ☐ No ☐ Yes, Last does when? _____

****Patient/Responsible Person Signature**:** _____ Date: _____ Time: _____

VITAL SIGNS: **BLOOD PRESSURE** _____ **HEART RATE** _____
RESPIRATORY RATE _____ **TEMPERATURE** _____

Reviewed By: _____ Date: _____ Time: _____

Physician Signature: _____ Date: _____ Time: _____

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AUTHORIZATION FOR PHOTOGRAPHIC RECORDING

Name: _____ DOB: _____
Last **First** **MI**

In conjunction with medical services received at the offices of Rocco C. Piazza, MD, I hereby authorize photographs to be taken of my face or parts of my body under the following conditions:

1. The photographs may be taken only upon the request of, or with the consent of, Rocco C. Piazza MD

2. The physician or PIAZZA staff member so authorized by the physician shall take the photographs.

3. Photographs may be used for:
   a. Medical record documentation of my care;
   b. Photographs if deemed by judgment of the physician, will benefit medical research, education, or science;
   c. Photographs and information relating to my care may be published, either separately or in connection with each other, in professional journals or texts;
   d. Information and education on the website Rocco C. Piazza, MD, www.thepiazzacenter.com. I understand that the general public will have access to view these photos.

   In all cases where photographs are to be used outside of medical record documentation, due care will be taken in preserving patient anonymity.

4. I hereby grant permission for the use of any of my medical records including illustration, photographs or other imaging records created in my case, for use in examination, testing, credentialing and/or certifying purposes by The American Board of Plastic Surgery, Inc.

5. I authorize the release of any photographs to my insurance company for assistance in obtaining prior authorization for surgery, or in promoting effective processing of claims related to my care as may be judged necessary.

6. I waive all rights, claims and/or interest pertaining to these photographic records and further, do waive all rights to payment and/or royalties in connection with their use and/or publication.

This authorization is valid until it is withdrawn by written notice from the patient/parent/legal guardian.

I certify that I have read, or have had read to me, and do understand this authorization form and its contents.

Signature: _____ Date: _____

Above Signature By: ☐ Parent ☐ Patient ☐ Legal Guardian

Witness: _____ Date: _____