

Jennifer S. Landy, MD

2835 W. DeLeon Street Suite 206 Tampa, FL 33609

Phone: 813.870.3702 Fax: 813.870.3595 www.landyplasticsurgery.com

Date: _____

PATIENT INFORMATION

Last Name _____ First Name _____ Middle Name _____

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

Social Security Number _____ Driver's License _____

Home Street Address _____

City _____ State _____ Zip _____ Home Phone _____

Email Address _____ Cell Phone _____

Employer _____ Occupation _____

Work Address _____

City _____ State _____ Zip _____ Work Phone _____ Ext _____

Spouse's Name _____ Phone _____

Spouse's Social Security Number _____ Occupation _____

Emergency Contact Person _____ Relation _____

Home Address _____ Phone _____

Who referred you to us? _____ Phone (If Dr. Referred) _____

INSURANCE INFORMATION

Insurance information type: CASH (Cosmetic Procedures) MEDICARE

Medicare No. _____ Effective Date ____/____/____

Insurance Name _____ Effective Date ____/____/____

Address _____ Phone _____

Cert # _____ Group # _____

Subscriber _____ SS# _____ DOB _____ Relation _____

AUTHORIZATION TO PAY MEDICAL OR SURGICAL BENEFITS DIRECTLY TO PHYSICIAN:

I hereby authorize my insurance _____ to make payments directly to Jennifer S. Landy, MD for all surgical and medical expense benefits otherwise payable to me for this period of treatment. I understand that I am financially responsible for all charges not covered by my insurance benefits. I also authorize release of my records to the insurance company for the purpose of billing.

Patient / Parent / Guardian / Insured

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Patient Name _____ Today's Date _____

REASON FOR VISIT / MAIN CONCERN _____

Primary Physician _____ Location _____

Physician Phone _____ Date Last Physical _____

PRESCRIPTION MEDICATIONS (PLEASE INCLUDE NAME, DOSE AND NUMBER PER DAY)

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

NON PRESCRIPTION MEDICATIONS (LIST OVER THE COUNTER, HERBAL, AND VITAMINS)

- | | | |
|----------|----------|----------|
| 1. _____ | 4. _____ | 7. _____ |
| 2. _____ | 5. _____ | 8. _____ |
| 3. _____ | 6. _____ | 9. _____ |

***DO YOU HAVE ANY ALLERGIES OR REACTIONS TO ANY MEDICATIONS: NO _____ YES _____

- | | |
|------------|-----------------|
| MED: _____ | REACTION: _____ |
| MED: _____ | REACTION: _____ |
| MED: _____ | REACTION: _____ |

***HAVE YOU EVER HAD A REACTION TO ANY ANESTHETICS? N / Y

***WHEN YOU GO TO THE DENTIST, DOES HE/SHE HAVE A HARD TIME NUMBING YOU? N / Y

REVIEW OF SYSTEMS: (PLEASE CIRCLE IF YOU HAVE OR HAVE HAD IN THE PAST 12 MONTHS***)

- | | | | |
|-----------------------|------------------------|--------------------------|--------------------|
| GENERAL | EYES | EAR,NOSE,THROAT | SKIN |
| Weight Loss | Double Vision | Hearing Loss | Bruise Easily |
| Fever | Dry Eyes | Ringing in Ears | Rashes |
| Night Sweats | Redness | Sore Throat | Change in Moles |
| Depression | Pain | Bloody Nose | Scars |
| CARDIOVASCULAR | RESPIRATORY | GASTRONINTESTINAL | URINARY |
| Heart Palpitations | Chronic Cough | Constipation | Frequent Urination |
| Chest pain | Bloody Sputum | Diarrhea | Blood in Urine |
| Heart Racing | Short of Breath | Blood in Stools | Painful Urination |
| Ankle Swelling | Wheezing | Excessive Thirst | Lack of Control |
| NEUROLOGICAL | MUSCULOSKELETAL | HEMATOLOGIC | ALLERGIC |
| Headaches | Joint Pain | Bleeding Gums | Swelling |
| Dizziness | Muscle Pain | Unexplained Bleed | Hives |
| Numb Arms/Legs | Weak Arms/Legs | Transfusion | Redness/Scaling |

***IF NONE OF THESE APPLY, PLEASE INITIAL HERE: _____

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CONDITIONS: (PLEASE CIRCLE ALL THOSE THAT APPLY)

Heart Disease	Diabetes	Asthma or Emphysema
High Blood Pressure	Arthritis	Hepatitis or Liver Disease
Psychiatric Care	HIV or AIDS	Alcohol or Drug Dependency
Thyroid Problems	Kidney Disease	Tuberculosis
Cancer (Type and Treatment)	_____	
Other (Please Specify)	_____	

EYE AND FACIAL HISTORY

Have you had any visual Problems?	NO	YES
Do you wear glasses or contacts?	NO	YES
Do you have dry or watery eyes?	NO	YES
Have you had Cataract, Laser or other eye surgery?	NO	YES
Have you had Trauma or Injury to your eyes?	NO	YES
Do you have Glaucoma?	NO	YES
Have you ever had Bell's Palsy?	NO	YES

PAST SURGICAL HISTORY:

Date _____	Surgery _____	Dr. _____
Date _____	Surgery _____	Dr. _____
Date _____	Surgery _____	Dr. _____

SOCIAL HISTORY

Do you smoke? Quit (When?) _____ Yes (How Much?) _____ No _____
Do you drink Alcohol? No _____ Occasionally _____ Daily _____
What is your weight? _____ For you, is this Low _____ Normal _____ High _____

ADDITIONAL INFORMATION YOU THINK WE SHOULD KNOW:

I UNDERSTAND THAT THE ABOVE ANSWERS ARE IMPORTANT FOR MY SAFETY DURING AND AFTER SURGERY OR MEDICAL CARE AND I, THEREFORE, CERTIFY THAT ALL OF THE ABOVE ANSWERS ARE TRUE TO THE BEST OF MY KNOWLEDGE.

Patient Signature

Date

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HIPAA ACKNOWLEDGEMENT AND PRIVACY PREFERENCES

You may be contacted by our office to remind you of appointments, Healthcare Treatment Options or other Health Services that may be of interest to you. To Maintain your Privacy, please answer the following:

May we contact you at home?	YES	NO	Ok to leave Message?	YES	NO
May we contact you at work?	YES	NO	Ok to Leave Message?	YES	NO
May we contact you VIA Cell?	YES	NO	Ok to Leave Message?	YES	NO

If it is ok to leave a message, does that include.....

Practice Name and Phone Number Only	YES	NO
Detailed or Specific Message	YES	NO

Would you like to authorize someone else to schedule, confirm, or change appointments?

If So, Please Provide: Name _____ Phone: _____

For the purpose of marketing, advertising, special events and offers, may we contact you via email and/or newsletter? YES NO

Jennifer S. Landy, MD has provided me with a copy of my rights as a patient under the HIPAA (Health Insurance Portability and Accountability) ACT. I have been provided the opportunity to read and understand my rights (Please ask receptionist for a copy to read). I have been provided the opportunity to ask questions regarding my rights and received answers to my satisfaction.

Patient Signature

Date

Witness

PHOTOGRAPHIC CONSENT

(Dr. Landy cannot perform any procedures without a signed photo consent)

In connection with the medical services that I am receiving from Jennifer S. Landy, MD, I consent that photographs may be taken of me under the following conditions:

1. The photographs may be taken only with the consent of my surgeon and under such conditions and such times as may be approved by her.
2. The photographs shall be taken by my physician or by a competent photographer, approved by my physician.
3. These photographs shall be used for medical records only, unless in the judgement of my physician, medical research, education or science will benefit by their use.

Patient Signature

Patient Printed Name

Witness

Date

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IF YOU HAVE ANY SPECIFIC COSMETIC INTERESTS, PLEASE CHECK ALL THAT APPLY:

- | | |
|---|--|
| <input type="checkbox"/> Face Lift | <input type="checkbox"/> Botox |
| <input type="checkbox"/> Mini Face Lift | <input type="checkbox"/> Restylane |
| <input type="checkbox"/> Neck Lift | <input type="checkbox"/> Sculptra |
| <input type="checkbox"/> Neck Liposuction | <input type="checkbox"/> Radiesse |
| <input type="checkbox"/> Brow Lift | <input type="checkbox"/> Juvederm |
| <input type="checkbox"/> Eyelid Lift | <input type="checkbox"/> Perlane |
| <input type="checkbox"/> Cheek Lift | <input type="checkbox"/> FotoFacial / Intensive FotoFacial |
| <input type="checkbox"/> Laser Resurfacing | <input type="checkbox"/> Treatment of Age Spots / Freckles |
| <input type="checkbox"/> Lip Augmentation | <input type="checkbox"/> Laser Vein Removal |
| <input type="checkbox"/> Scar Revision | <input type="checkbox"/> Laser Hair Removal |
| <input type="checkbox"/> Skin Care Treatment | <input type="checkbox"/> Microdermabrasion |
| <input type="checkbox"/> Retinoic & Glycolic Peel | <input type="checkbox"/> SmartLipo (Laser Liposuction) |

Please answer the following questions on a scale of 1 to 5 by circling the appropriate number:

When looking at my face in the mirror, I believe I look younger, the same as, or older than my true age.

Younger than		True Age		Older Than
1	2	3	4	5

Each Day, I look at myself in the mirror:

Once or Twice Per Day	Every Now and then to fresh up	More than 10 times a day		
1	2	3	4	5

I am looking for a procedure that can give me a:

Small Improvement with Minimal Down-time	Moderate Improvement with some down-time	Significant Improvement with longer down-time		
1	2	3	4	5

HOW DID YOU HEAR ABOUT US?

- My Physician (Name) _____
- Website
- The Yellow Pages / Telephone Book
- A Friend or Family Member (name) _____ May we Contact Y N
- Internet Search (Google Yahoo Other _____)
- Newsletter or Mailer
- An Article or Advertisement in _____