PLASTIC SURGERY CENTER OF TAMPA
JAIME PEREZ, M.D., FACS AND TRACI M TEMMEN, M.D.
Plastic & Reconstructive Surgery
307 S Macdill Ave.
TAMPA, FL 33609
PHONE: (813)877-3739 FAX (813)877-3738

PATIENT INFORMATION SHEET

Date: _____

Last Name _____ First Name _____ MI _____

SSN# _____-_____-_____ DOB ___/___/____ Age _____ Sex _____Relationship Status _____

Home Address

_____

City _____State _____ ZIP _____

Home Phone_____ Work _____ Cell _____

Occupation _____ Employer/School _____

E-mail address

_____

Reason for visit? _____

Who referred you or how did you find out about us? _____

Health Insurance Company _____ Policy # _____

SPOUSE/PARENT/SIGNIFICANT OTHER

Last Name _____First Name _____Relationship_____

Address _____

City _____ State _____ ZIP _____

Home _____ Work _____ Cell _____

EMERGENCY CONTACT(s)

❒ Same as above

1) Name _____ Relationship _____

Home _____ Work _____ Cell _____

2) Name_____ Relationship _____

Home _____ Work _____ Cell _____

Signature _____ Date _____

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Jaime Perez, M.D
Traci M Temmen, M.D

PATIENT MEDICAL HISTORY

Patient Name: _____ Age: _____ Sex: _____ Height: _____ Weight: _____

Drug Allergies: _____ Date of last Tetanus: _____

List all medications taken on a regular basis: (Please include over the counter medications current prescriptions)

_____

Do you smoke: ❒ YES ❒ NO Amount/Type: _____ Alcohol: ❒ YES ❒ NO Amount:_____

Please list all medical problems and past surgeries: (Please include year of surgery)

_____

Have you ever had any complications with general anesthesia? ❒ YES ❒ NO

Are you pregnant? ❒ YES ❒ NO ❒ UNKNOWN Date of your last menstrual period _____

Year of last Mammogram _____

Do you have children? ❒ YES ❒ NO If so how many? _____ Ages _____

PLEASE CHECK AND DATE ALL THAT APPLY

✓		✓		✓	
	ADRENAL DISEASE		DIABETES		MUSCLE WEAKNESS
	ANEMIA		DIFFICULTY SWALLOWING		NASAL OBSTRUCTION
	ARTHRITIS		DIZZINESS		NAUSEA / VOMITING
	ASTHMA		DIVERTICULITIS		NERVE INJURY
	BACK PAIN		EMPHYSEMA		PACE MAKER
	BLADDER INFECTIONS		EPILEPSY / SEIZURES		PERSISTENT HOARSENESS
	BLEEDING TENDENCIES		EYE OR VISION PROBLEMS		PITUITARY DISEASE
	BLOOD DISEASE		GALL BLADDER DISEASE		PNEUMONIA
	BLOOD IN STOOL		GLAUCOMA		PROSTATE PROBLEMS
	BLOOD IN URINE		HEADACHES		RHEUMATIC FEVER
	BLOOD PRESSURE (HIGH)		HEARING PROBLEMS		SEVERE NERVOUSNESS
	BLOOD PRESSURE (LOW)		HEART DISEASE		SHORTNESS OF BREATH
	BREAST PROBLEMS		HEPATITIS		SINUSITIS
	BROKEN BONES		HERNIA		STROKE
	BRONCHITIS		HIVES / RASH		SWOLLEN LYMPH NODES
	CANCER		HIV/AIDS		THYROID / GOITERS
	CHEST PAIN		JOINT PAIN		WEIGHT GAIN (RAPID)
	CHRONIC COUGH		KIDNEY DISEASE		WEIGHT LOSS (RAPID)
	CIRRHOSIS		MENTAL DEPRESSION		IRREGULAR HEARTBEAT
	CONSTIPATION		MISCARRIAGES		OTHER
	CYSTS		MONONUCLEOSIS		

_____ _____

Patient's Signature (or Parent, if patient is a minor Date

Jaime Perez, M.D.
Traci M. Temmen, M.D.
Plastic Surgery Center of Tampa

PATIENT RECORD OF DISCLOSURES

Patient Name: _____ Date: _____

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information. *(PHI)*. The individual is also provided the right to request confidential communications or that a communication of *PHI* be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

Plastic Surgery Center of Tampa typically communicates with their patient's by telephone. If you do not approve of this method or have an alternate manner of communication, please provide us with this information by completing the following:

How would you like to be contacted regarding appointments, treatment and/or other information pertinent to your healthcare and/or payment for your healthcare provided at Plastic Surgery Center of Tampa (check all that apply):

VERBAL COMMUNICATIONS

Home Telephone: _____

- & Speak only to the patient
- & Leave a detailed message on answering machine
- & Leave call back number only

Work Number: _____

- & Speak only to the patient
- & Leave a detailed message on voicemail
- & Leave call back number only

WRITTEN COMMUNICATIONS

& O.K. to mail to home address Home Address: _____

& O.K. to mail to work address Work Address: _____

Fax Number: _____

- & O.K. to fax to this number a detailed message
- & Leave a call back number or fax number only

Please list any other restrictions regarding messages or reminders about your healthcare or account:
Please list below any other persons authorized to discuss your account.

_____

_____

Patient Signature: _____

Plastic Surgery Center of Tampa
Patient Bill of Rights

Section 381.026, Florida Statutes, addresses the Patient's Bill of Rights and Responsibilities. The purpose of this section is to promote the interests and well being of patients and to promote better communication between the patient and the health care provider. Florida law requires that your health care provider or health care facility recognize your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities follows.

A patient has the right to:

Be treated with courtesy and respect, with appreciation of his or her dignity, and with protection of privacy.

Receive a prompt and reasonable response to questions and requests.

Know who is providing medical services and who is responsible for his or her care.

Know what patient support services are available, including if an interpreter is available if the patient does not speak English.

Know what rules and regulations apply to his or her conduct.

Be given by the health care provider information such as diagnosis, planned course of treatment, alternatives, risks, and prognosis.

Refuse any treatment, except as otherwise provided by law.

Be given full information and necessary counseling on the availability of known financial resources for care.

Know whether the health care provider or facility accepts the Medicare assignment rate, if the patient is covered by Medicare.

Receive prior to treatment, a reasonable estimate of charges for medical care.

Receive a copy of an understandable itemized bill and, if requested, to have the charges explained.

Receive medical treatment or accommodations, regardless of race, national origin, religion, handicap, or source of payment.

Receive treatment for any emergency medical condition that will deteriorate from failure to provide treatment.

Know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such research.

Express complaints regarding any violation of his or her rights.

A patient is responsible for:

Giving the health care provider accurate information about present complaints, past illnesses, hospitalizations, medications, and any other information about his or her health.

Reporting unexpected changes in his or her condition to the health care provider.

Reporting to the health care provider whether he or she understands a planned course of action and what is expected of him or her.

Following the treatment plan recommended by the health care provider.

Keeping appointments and, when unable to do so, notifying the health care provider or facility.
His or her actions if treatment is refused or if the patient does not follow the health care provider's instructions.

Making sure financial responsibilities are carried out.

Following health care facility conduct rules and regulations.

I acknowledge that I have read and understand the Patient's Bill of Rights.

_____ _____

Signature Date

Plastic Surgery Center of Tampa

Jaime Perez, M.D.

Traci M. Temmen, M.D.

Pre-Operative Questionnaire for Malignant Hyperthermia

1. Does patient have a family history of unexpected death(s) following general anesthesia?
   Yes No _____
2. Has family or personal history of MH, a muscle or neuromuscular disorder?
   Yes No _____
3. High temperature following exercise?
   Yes No _____
4. Personal history of muscle spasm, dark or chocolate colored urine?
   Yes No _____
5. Unanticipated fever immediately following anesthesia or serious exercise?
   Yes No _____
6. History of blood clots or venous thrombosis?
   Yes No _____

_____ _____

Patient's Signature (or Parent, if patient is a minor) Date

Plastic Surgery Center of Tampa
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Pre-Operative Questionnaire for Bleeding and /or Clotting Disorders

BLEEDING DISORDERS:

1. Do you have a history of unexplained bleeding or easy bruising causing you to seek medical treatment before? Yes No
2. Do you have a history of chronic anemia? Yes No
3. Have you had weight-loss surgery in the past? Yes No
4. Have you or your doctors ever had difficulty getting bleeding to stop after dental work, minor injuries, or surgeries? Yes No
5. Do you or a family member have a history of hemophelia? Yes No

CLOTTING DISORDERS:

1. Have you had recent elective hip or knee joint replacement surgery? Yes No (5)
2. Have you had a broken hip, pelvis, or leg in the last month? Yes No (5)
3. Have you had a serious trauma (e.g. car accident, broken bone, major fall) within the last month? Yes No (5)
4. Have you had a spinal cord injury or paralysis in the last month? Yes No (5)
5. Have you ever had a blood clot in your legs or lungs? Yes No (3)
6. Do you have a family history of blood clots in the veins, legs, or lungs? Yes No (3)
7. Do you have a family history of blood-clotting disorders? Yes No (3)
8. Have you had more than three days of continuous bed rest due to injury or illness in the past month? Yes No (2)
9. Have you had a catheter or tube in your neck or chest that delivers blood or medicine directly to the heart (also called central venous access) within the last month? Yes No (2)
10. Have you had a broken limb that required a cast in the past month? Yes No (2)
11. Have you had a major surgery lasting more than an hour in the last month? Yes No (2)
12. Do you have or have you ever been diagnosed with cancer? Yes No (2)
13. Do you have leg swelling every day? Yes No (1)
14. Do you have visible varicose veins or spider veins? Yes No (1)

15. Do you have inflammatory bowel disease? Yes No (1)

16. Do you have emphysema or COPD? Yes No (1)

17. Have you had a heart attack or heart failure? Yes No (1)

18. Have you had a serious infection (e.g. pneumonia or kidney infection) in the last month? Yes No (1)

19. Are you overweight, obese, or weight over 250 lbs? Yes No (1)

20. What is your age? Circle One:

Under 40 41-59 (1pt) 60-74 (2pts) 75 and over (3pts)

For Women Only:

21. Do you use birth control pills or estrogen therapy? Yes No (1)

22. Are you pregnant or have you had a baby within the last month? Yes No (1)

23. Do you or a family member have a history of multiple unexplained miscarriages Yes No (1)

Clotting Disorders Total Score:_____
(Add all points for a "yes" answers and age group.)

Score	Risk Assessment	Recommended Prophylaxis Regimen*
0 to 2	Very Low to Low	Early ambulation and/or SCD's during surgery
3 to 5	Moderate to High	Early ambulation, SCD's during surgery, and prophylactic Lovenox given in surgery then continued until ambulating well.

Your Risk Assessment is:_____
(Very Low to Low -OR- Moderate to High)

_____ _____
Patient's Signature (or Parent, if patient is a minor) Date

* This is a general guideline, not a guarantee of appropriate risk stratification, prevention, and/or proper treatment. Always discuss clotting disorder risk assessment and prophylaxis/treatment recommendations with your doctor.

JAIME PEREZ M.D.
Plastic Surgery Center of Tampa

How long have you been considering this procedure?

_____

When are you planning to have your procedure performed?

_____

Are you interested in learning about financing options during your consult?

_____

Do you smoke? _____ If so, How much per day, for how long, and are you willing to refrain from smoking as recommended by the doctor prior to your procedure? _____

Do you have any particular questions we could answer for you in reference to your desired procedure?

(sometimes people forget their questions once they enter the examination room, it's normal)

_____

_____

_____

An overview of your visit today:

You will meet with a consultant first to get familiar with the office and inform you about the doctor and desired procedure.
You will meet the doctor and have the opporunity to ask more questions and will be examined shortly afterwards.
After your examination you will come into another room where you will be presented with pictures of patients who have had similar procedures performed, after which prices will be discussed.

Please feel free to take your time and ask any and all questions you may have as we are here to dedicate time and attention to you

AUTHORIZATION FOR AND RELEASE OF MEDICAL PHOTOGRAPHS / SLIDES / AND/OR VIDEO FOOTAGE AUTHORIZATION FOR RELEASE OF PATIENT IMAGE

Name _____

Address _____
(street address, city, state and zip code)

I consent to the taking of photos, slides or video footage by Dr. Jaime Perez or his designee of me or parts of my body in connection with the plastic surgery procedure(s) to be performed by Dr. Jaime Perez. I further authorize Dr. Jaime Perez or one of his/her associates to release to the American Society of Plastic Surgeons ("ASPS") such images.

I provide this authorization as a voluntary contribution in the interests of public education. I understand that such photographs shall become the property of ASPS and may be retained by ASPS or released by ASPS for the limited purpose of including them in any print, visual or electronic media, specifically including, but not limited to, medical journals and textbooks, for the purpose of informing the medical profession or the general public about plastic surgery procedures and methods.

Neither I, nor any member of my family, will be identified by name in any publication., I understand that in some circumstances the images may portray features that will make my identity recognizable.

I understand that I may refuse to authorize the release of any health information and that my refusal to consent to the release of health information will prevent the disclosure of such information, but will not affect the health care services I presently receive, or will receive, from Dr. Jaime Perez.

I understand that I have the right to inspect and copy the information that I have authorized to be disclosed. I further understand that I have the right to revoke this authorization in writing at any time, but if I do so it won't have any affect on any actions taken prior to my revocation. If I do not revoke this authorization, it will expire one year from the date written below.

I understand that the information disclosed, or some portion thereof, may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). I further understand that, because ASPS is not receiving the information in the capacity of a health care provider or health plan covered by HIPAA, the information described above may no longer be protected by HIPAA.

I release and discharge Dr. Jaime Perez, ASPS, and all parties acting under their license and authority from all rights that I may have in the photographs and from any claim that I may have relating to such use in publication, including any claim for payment in connection with distribution or publication of the photographs.

I certify that I have read the above Authorization and Release and fully understand its terms.

_____ _____
Signature Date

I have read the above Authorization and Release. I am the parent, guardian, or conservator of _____ _____, a minor. I am authorized to sign this authorization on his/her behalf and I give this authorization as a voluntary contribution in the interest of public education.

_____ _____
Signature Date