Manuel M. Peña, M.D., P.A.
6370 Pine Ridge Road, Suite 101
Naples, Florida 34119
(239) 348-7362
Fax (239) 352-4999

Patient Registration

Name ______________________________ Birth Date ______________

Address ____

City ____________________ State ______________ Zip ______________

Home Phone ____________________ Work Phone & Ext. ______________

Marital Status M S W D Cell Phone ____________________

Social Security # ______________________________ Sex __________

How did you hear of us? ______________________________

Reason for this visit? ______________________________

E-MAIL ____

Do you have a northern address? Yes No

Address ____

City ____________________ State ______________ Zip ______________

Telephone (________) ____________________

The above information is true and correct: (please sign below)

______________________________ ______________

Patient's Signature Date

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Health History

Name: ______________________________ **Date:** ____________________
(please print)

What is the purpose of this consultation? What would you like to correct and what are your aesthetic goals?

____

____

Yes No **Have you ever consulted a plastic surgeon before?**
Yes No **Have you ever had plastic surgery before?** (Please describe, including dates)

____

Yes No **If you have had plastic surgery, are you satisfied with the results?**

Please list any surgeries you have had within the past ten (10) years?

____

Have you had any of the following? (Please circle any procedures you have had)

Collagen	Accutane	Skin Cancer
Botox	Chemical Peel	Restylane
Dermabrasion	Radiance	Radiation Treatment

Please list any additional procedures you have had such as stress test/cardiac catherization.

____

Yes No **Have you had any problems with anesthesia in the past?** Has anyone in your family?______________________________

Yes No **During any previous anesthesia, have you or any member of your family had anything unusual happen such as significant allergic reaction or difficulty emerging or coming off anesthesia?** If yes, please describe the situation. ________

____

Please describe reasons for any other hospital admission within the past ten (10) years?

____

Yes No **Do you heal well?**

Yes No **Do you bruise easily?**

Yes No **Do you scar badly?**

Yes No **Have you ever taken cortisone, predisone, or any other cortisone-type of steroid medication?**

What medications do you take now (including vitamins, aspirin, etc.)? Please do not omit anything as medications used during and after surgery may interact adversely.

Medication	Dosage	Frequency	Purpose

Yes No **Have you ever had a bad reaction or an allergic reaction to any medication or to adhesive tape?** (Please describe reaction from medication.)

____

Yes No **Do you smoke?** For how long?________ years How many? ________ per day. When did you quit?________

Please describe your alcohol consumption? (daily, weekly, monthly?) (quantity?)

____

Yes No **Do you, or in the past, have you had, frequent regular prolonged direct exposure of your skin to the sun or sun-tanning devices?**

Yes No **Are you allergic to any skin medications, lotions or creams?** If yes, please list what medicines, lotions, or creams that you currently use on your skin.

____

Have you ever been diagnosed with the following: (please indicate any of the following by circling *yes* or *no* and then circle the specific diagnosis.)

Yes No Angina, coronary artery disease, or heart valve problem?

Yes No Asthma, emphysema, chronic bronchitis, lung cancer, or any other serious pulmonary problems which may contribute to shortness of breath?

Yes No History of pulmonary emboli or blood clots from your legs to your lungs?

Yes No Kidney disease of any kind including kidney failure, kidney stones, or prostate enlargement?

Yes No Diabetes requiring medication or insulin? What dose?

Yes No Arthritis or any type of rheumatoid or osteoarthritis, degenerative joint disease?

Yes No Lupod, sarcoid, or any other autoimmune disorder?

Yes No History of tuberculosis, hepatitis, or HIV infection?

Yes No Circulation problems such as blocked arteries in the legs causing leg pain when you walk, blood clots in your legs such as a deep venous thrombosis, or history of varicose veins?

Yes No Easy or free bleeding, history of leukemia, or lymphoma? Have you been told that you are anemic in the past?

Yes No Chronic gastrointestinal problems such as ulcers, diarrhea, constipation, or tumors (benign or malignant) of the GI tract?

Yes No History of seizures or other neurological disorders such as headaches, including migraines and tension headaches or dizziness?

Yes No Seasonal allergies or history of contact dermatitis?

Yes No Visual impairment such as glaucoma or cataracts? Have you had laser treatments to the eyes? Do you have dry eye syndrome?

Yes No Do you have allergies to eye drops, eye ointment, or eye make-up?

Yes No Do you wear dentures?

If you have answered "Yes" to any of the above, please explain: ______________________________

____

____

Yes No Are you currently under the care of or do you have a physician you call or visit for medical problems?

Name: ____

Address: ____

Phone: ____

Yes No May we consult, if necessary, with your physician?

Thank you for completing this health history form. All information will be kept confidential and as part of your medical records.

Your Pharmacy: ______________________________ Phone: ______________________________

I, ____________________, state that the above information is true and correct: (please sign below)

____ ______________________

Patient's Signature Date

Manuel M. Peña, M.D., P.A.
Plastic and Reconstructive Surgery

PHOTOGRAPHIC AUTHORIZATION

PATIENT NAME ____

DATE ____________________________

PHOTOGRAPHS ARE ESSENTIAL FOR THE OPTIMUM MANAGEMENT AND MONITORING OF YOUR SURGERY OR MEDICAL CONDITION. PHOTOGRAPHS ARE MANDATORY AND NO SURGERY WILL BE PERFORMED WITHOUT THEM. THE PHOTOGRAPHS MAY BE USED, WITHOUT NAMES OR IDENTIFYING MARKS, FOR SCIENTIFIC/MEDICAL REASONS.

PHOTOGRAPHS ARE OFTEN REQUIRED BY INSURANCE COMPANIES AND THIRD PARTY PAYORS TO SUBMIT FOR COVERAGE OF PLANNED SURGICAL PROCEDURES. THESE WILL BE PROVIDED UNLESS YOU CHOOSE FOR THEM NOT TO BE SENT.

THE PHOTOGRAPHS/SLIDES ARE THE PROPERTY OF DR. MANUEL M. PEÑA. YOU HAVE THE RIGHT TO HAVE A COPY/COPIES FOR A DUPLICATING FEE.

I, ____,
NAME OF PATIENT

HAVE READ THIS AND UNDERSTAND THE ABOVE, AND GIVE THE AUTHORIZATION FOR PHOTOGRAPHS TO BE TAKEN.

______________________________ ____________________
PATIENT DATE

______________________________ ____________________
WITNESS DATE

HIPAA Notice of Privacy Practices

Dr. Manuel M. Peña, M.D., P.A.
6370 Pine Ridge Road, Suite 101
Naples, FL 34119
(239) 348-7362

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment of health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, which may identify you and that related to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of you physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conduction or arranging for other business activities. For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operation. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosure we have made, if any, of your protected health information.

We reserved the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Offices in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: ______________________ Date: ______________

Signature: ______________________