

GREGORY J. STAGNONE, M.D., P.A.
6190 LBJ Frwy., Ste. 500
Dallas, TX 75240

Date: _____

Last Name: _____			First: _____			Middle: _____		
Date of Birth: ____/____/____		Age: _____		Social Security # _____ - _____ - _____				
Address: _____			City _____		State: _____		Zip _____	
Home: (____) _____		Cell: (____) _____		Other: (____) _____				
E-Mail Address: _____								
Occupation: _____				If Retired, Date: _____				
Employer: _____				Work # : (____) _____				
Address: _____			City _____		State: _____		Zip _____	

Marital Status: Single Married Other _____

Spouse's Name: _____ Spouse's Date of Birth: ____/____/____
(or parent, if patient is a minor)

Spouse's Employer: _____

Spouse's Cell # : (____) _____ Spouse's Work # : (____) _____

***Any other number you may be reached at on the day of surgery for last minute changes in the surgery schedule: (____) _____**

***Number you will be staying at after surgery: (____) _____**

May we leave any necessary messages for you at work? Yes/No _____
Initial _____

Can we leave messages on your home answering machine? Yes/No _____
Initial _____

Next of Kin Not Living With You – For Emergency Contact

Name: _____ Relationship: _____

Address: _____

Home: (____) _____ Cell: (____) _____ Work : (____) _____

How did you hear about our office? _____

If you were referred by a patient, please list his/her name.

Please tell us what you are here to discuss.

**PLASTIC SURGERY CENTER OF DALLAS
FINANCIAL ARRANGMENTS AND OFFICE POLICIES**

We are committed to providing you with the best possible care. The following is a statement of our financial policies which we request that you read and acknowledge prior to any treatment.

Scheduling and Cancellation Policy

Full payment for cosmetic procedures is due two weeks prior to surgery or at time of scheduling. To reserve a surgical date, a deposit of 50 % or \$2000 is required. We accept payment by cash, cashier's check or major credit card.

After your consultation with Dr. Stagnone and your surgery is scheduled, there will be a separate pre-operative appointment to thoroughly review the details of your surgery, obtain prescriptions, sign consent forms and complete all arrangements. **If surgery is cancelled at any time following your pre-operative appointment, there will be an administrative fee of 10% of your quoted fee deducted from your refund, in addition to any expenses we have incurred (lab fees, shipping charges, etc.)** If surgery is cancelled within five working days of your procedure, 50% of your quoted fee will be refunded. Failure to show up for your scheduled surgery will result in forfeiture of 100% of your fees.

We very much understand that personal emergencies may come up unexpectedly, requiring that your surgery be rescheduled. Because of this we do allow the above penalties to be applied towards rescheduled surgery one time. Multiple cancellations resulting in filled time are very costly to us. Therefore, if rescheduling is requested a second time there will be a 10% surcharge penalty which must be prepaid. All fees will be 100% forfeited in the event of a third cancellation. Forfeited funds will not be applied to future procedures.

Patient signature/date

Photography

Medical photography is essential for legal documentation of your pre-operative condition and for planning of cosmetic surgery as well as medical education.

I consent to photography of appropriate portions of my face or body in preparation for surgery and for postoperative follow up.

Patient signature/date

I consent to the use of my photos for patient education or other educational or promotional purposes, providing that my identity is not revealed.

Patient signature/date

Revisions or complications

If there are necessary revisions to surgery, there will be no surgeon's fee. However, you would be responsible for anesthesia and operating room charges. This revision policy is confined to the 8-month period following your surgery unless other arrangements are made in advance of 8 months time. This policy does not apply to laser treatments or liposuction. (Please discuss these with the doctor.)

Patient signature/date

HISTORY & PHYSICAL

NAME: _____ Date: _____

SOCIAL HISTORY

Age: _____ Sex: M F Weight: _____ Height: _____ Married: Y N Occupation: _____

Do You Have a Responsible Adult Available to Assist During Recovery Period Y N Relationship: _____

HABITS

Smoke: Y N Amount: _____ Alcohol: Y N Amount: _____

Drug Allergies: Y N List drug(s) and type of reaction: _____

Latex Allergy: Y N Tape Allergy: Y N Anesthesia Allergy: Y N

MEDICATIONS: List dose or number of pills per day

Prescription Drugs

Non-Prescription (Vitamins; Herbs)

Regular Aspirin Use: Y N Dosage & Frequency: _____

NSA (Advil, Motrin, Ibuprofen): Y N Dosage & Frequency: _____

FAMILY HISTORY:

Have any blood relatives ever had the following problems:

Abnormal Bleeding: Y N Abnormal Clotting: Y N Anesthetic Problems: Y N

Cancer: Y N Blood Clots in Legs: Y N

Please describe questions with a "Yes" answer: _____

PERSONAL PAST HISTORY: Have you ever had:

Abnormal Bleeding: Y N Asthma: Y N HIV: Y N

Abnormal Clotting: Y N Diabetes: Y N Hypertension: Y N

Anemia: Y N Heart Attack: Y N Weight change in past 12 Mo.: Y N

Angina: Y N Hepatitis: Y N Other Serious Illness: Y N

Please describe questions with a "Yes" answer: _____

Have you ever received a transfusion? Y N If yes, what year? _____

Have you been tested for HIV? Y N If yes, what year? _____ Test results: Positive Negative

Do you wear: Contact lenses: Y N Dentures: Y N Crowns/Veneers/Caps/Bonding: Y N

List all previous surgeries and any complications: _____

Date last seen by Primary Care Physician: _____

Primary Care Physician (name) _____ (telephone) (____) _____

(address) _____

FEMALE PATIENTS ONLY:

Number of pregnancies _____ Number of children _____ Last menstrual period _____

Have you had a tubal ligation or hysterectomy? Y N If yes, when? _____

Short Term Disability, Health Insurance & FMLA Paperwork Policy

If you are filing FMLA paperwork and/or Short Term Disability with your employer, please complete all paperwork prior to your pre-operative visit and bring it with you to your pre-op appointment. We are not staffed to complete these lengthy documents or forms and have not factored into our fees the time necessary to complete them. Forms which you have completed will be given to Dr. Stagnone to sign and will be returned to you on the day of surgery.

The Plastic Surgery Center of Dallas is a non-insurance facility, specializing only in elective aesthetic surgery. Filing health insurance claims requires insurance coding software and up to date code books that we do not have at this facility. We do not have insurance or billing staff and we do not complete and/or file any insurance paperwork. We will give you any information we have and/or records however, so that you may file for insurance benefits on your own behalf. For any exceptions to this policy, you would be billed as an additional service.

I fully understand the Plastic Surgery Center of Dallas' policy as described above.

Patient Signature

Date

Medical Photos

By signing this consent, I understand the photos taken before & after my surgery are for the purpose of chart documentation and are a part of my legal medical record. I fully understand photos will NOT be released, copied, emailed, or mailed to me. I acknowledge that I am responsible for taking my own before & after photos if I so choose.

Patient Signature

Date

