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: (____)_____

****Any other # you may be reached at the day of surgery for last minute changes** _____

****Pharmacy Telephone Number**_____ **Address**_____

Would you like to receive apt. confirmation via E-mail, Text message, or Both?_____

E-mail address: _____ Occupation: _____

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 #: (____)_____

Emergency Contact Information -

Name:_____ **Relationship:**_____

Address: _____

Home: (____)_____ Cell:(____)_____Work : (____)_____

How Did You Hear About Our Office? □ Patient _____ □ D Magazine □ Websearch
□ Top-Ten MD □ Sign/Drove By □ Personal Doctor _____ □ Real Self
□ Other _____

Please tell us what you are here to discuss. _____

Would you like information on any of our other services?

Surgery	**Injectables & Lasers**	**Skin Therapies**
□ Eyelids or Browlift	□ Botox	□ Acne
□ Nose Reshaping	□ Fillers (Juvederm)	□ Facial Discoloration
□ Neck, Chin Contouring	□ Laser Hair Removal	□ Facial Skin Retexturizing
□ Breast Implants	□ Laser Skin Tightening	□ Lip Enhancement
□ Breast Lift or Reduction	□ Laser Wrinkle Removal	□ Eyelash Enhancement
□ Tummy Tuck	□ Laser Correction of Skin Discoloration	□ Permanent Makeup □ Eyebrows □ Eyeliner
□ Labial Reshaping		
□ Liposuction, Body Contouring	□ Laser for Spider Vein	□ Lips □ Scar Camouflage
Other Areas_____	□ Correction of Eyelid Bags	□ Enzyme Therapy (smoothing)
_____	□ Lip Enhancement	□ Eye Rejuvenation

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? _____

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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 $2,060.00 is required (or $2000 by check or cash). We accept payment by cash, cashier's check, Care Credit financing or major credit cards.

After 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. Your balance is due in FULL at your pre-op appointment. If surgery is cancelled at any time following your pre-operative appointment, there will be an administrative fee of $500.00 deducted from your refund, in addition to any expenses we have incurred such as lab fees, shipping charges, financial transaction fees, 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. These will be addressed individually but we may allow the above penalties to be applied towards rescheduled surgery one time. Multiple cancellations resulting in unfilled time are very costly to us. Therefore, if rescheduling is requested a second time there will be a 15% 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. When using a finance company such as Care Credit, after your loan has been funded, any refunds will be based on their rules and policies in addition to those described above.

In the event of a dispute over payments or refunds with a credit card company or any other financial entity, we may have to disclose certain medical information to aid in resolution. For this reason, we require a HIPPA waiver for the use of credit. With your signature you hereby agree to waive your right to privacy under the Health Insurance Portability and Accountability Act of 1996 (HIPPA) guidelines only so that we may disclose whatever medical information is necessary to aid in the resolution of any such dispute.

_____ _____
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 6 week period following your surgery unless other arrangements are made in advance of 6 weeks time. This policy does not apply to laser treatments or liposuction. (Please discuss these with the doctor.)

_____ _____
Patient signature Date

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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

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

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

Plastic Surgery Center Of Dallas

Acknowledgement of Receipt of Notice of Privacy Practices

Print Name of Patient _____
Signature of Patient_____

If Patient is a minor:

Signature of patient Representative (Required if patient is a minor)_____
Relationship of Patient Representative to Patient_____

Please note that Sate and Federal Law provides additional protections for minors and restricts the release of certain patient information to anyone other than the minor patient.

Secure Phone Option: Is there a phone number where a message containing personal health information could be left in the event you are not available when we call?

YES **NO** If 'Yes', what is the number?_____

Please list any persons you would like to authorize to have access to your billing, appointments, or health information*. Such as your spouse, caretaker, or other family member:

NAME	RELATIONSHIP
_____	_____
_____	_____
_____	_____

*With the exculsion of information that is protected under State and Federal Law.