BREVARD COSMETIC SURGERY GROUP

BOARD CERTIFIED AMERICAN BOARD PLASTIC SURGERY

FRANK X. VENZARA MD
ROBERT L BASHORE MD
DAN DANIELS PA-C

WWW.BREVARDCOSMETICSURGERY.COM

VIERA HEALTH PARK
8725 WICKHAM RD STE 303
VIERA, FL 32940
P-321-622-8784
P-321-622-8789.

BREVARD SURGICAL CENTER
280 N SYKES CREEK PKWY STE A
MERRITT ISLAND, FL 32953
P-321-452-3882
P-321-454-7736

DATE:_____ REFERRED BY:_____

PATIENT INFORMATION (please print)

DOB:_____

NAME: _____ PHONE #_____

CELL PHONE #_____ OCCUPATION:_____

RACE:_____ HISPANIC____ NOTHISPANIC____ LANGUAGE:_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

E-MAIL ADDRESS:_____ PREFERRED METHOD OF CONTACT:_____

MARITAL STATUS: **M S D W** SEX: **M F** SOCIAL SECURITY# _____

EMPLOYER:_____ WORK PHONE# _____

ADDRESS: _____ CITY:_____ STATE:_____ ZIP:_____

SPOUSE OR PARENT INFORMATION

NAME:_____ DOB:_____ PHONE# _____

ADDRESS: _____ CITY:_____ STATE:_____ ZIP:_____

RELATIONSHIP: _____ SOCIAL SECURITY # _____

EMERGENCY CONTACT'S

NAME:_____ PHONE:_____ RELATIVE FRIEND NEIGHBOR

NAME:_____ PHONE:_____ RELATIVE FRIEND NEIGHBOR

CONTINUE IF THIS IS AN INSURANCE COVERED PROCEDURE

NOTE: IF YOUR INSURANCE IS CONTINGENT ON A REFERRAL / AUTHORIZATION/ PREADMISSION OR PRESURGICAL APPROVAL, OR SECOND OPINION IT IS YOUR RESPONSIBILITY TO INFORM US

PRIMARY INSURANCE INFO:

CARRIER: _____ ID# _____ GROUP#_____

INSURED (name on card):_____ RELATIONSHIP TO PATIENT: **SELF SPOUSE CHILD**

SECONDARY INSURANCE INFO:

CARRIER:_____ ID# _____ GROUP#_____

INSURED (name on card):_____ RELATIONSHIP TO PARIENT: **SELF SPOUSE CHILD**

MEDICARE PATIENTS: (please advise if you have a medicare advantage plan)

NAME OF BENEFICIARY:_____

MEDICARE#_____

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the holder of medical or other information about me to release to the Social Security Administration or it's intermediaries or carriers nay information needed for this or a related Medicare claim. I permit a copy of this authorization to ve used in place of the original. I request the payment of authorized benefits be made on my behalf. I assign the benefits payable for the physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a clain rfor Medicare for payment.

PATIENT SICNATURE:_____ DATE:_____

PRIMARY (NON-MEDICARE) & SECONDARY INSURANCE:
I hereby Authorize release of information neccessary to file a claim with:_____
Company and ASSIGN BENEFITS OTHERWISE PAYABLE TO ME TO BREVARD COSMETIC SURGERY GROUP OR FRANK X VENZARA MD OR ROBERT L BASHOREMD AS INDICATED ON THE CLAIM.

PATIENT
SIGNATURE:_____ DATE:_____

PATIENT RESPONSIBILITY
I understand I am financially responsible for any balance not covered by my insurance carrier (i.e. copay, co-insurance, deductible). In the event that the patient responsibility is not collected after three patient statements, our policy is to transfer your account to a collection agency as provided by the laws of the State of Frloida.

I understand that Brevard Cosmetic Surgery Group's doctors are consultants, working on a referral basis, and I am responsible for contacting my primary care physician or my insurance company regarding authorization and/or precertification.

I understand that all laboratory/pathology studies are done outside this office and are my resposibility.

PATIENT SIGNATURE:_____ **DATE:**_____

PARENT/GUARDIAN: _____ **DATE:**_____

HIPPA: PRIVACY ACT INFORMATION

I_____ acknowledge that I have received a copy of Drs. Venzara and Bashore's Notice of Privacy Practice. I also acknowledge being made aware of a copy of my Privacy Rights posted in Drs. Venzara and Bashore's waiting room, and a copy of said rights is available to me at my request.

PATIENT/GUARDIAN: _____ **DATE:**_____

HIPAA CONTACT INFORMATION FORM

In order to assist you in receiving your health information from Brevard Cosmetic Surgery Group, please complete this form. Initial one:

_____ (initial) BREVARD COSMETIC SURGERY GROUP is permitted to share **any and all** medical information with the individuals listed below, including test results, sensitive information as stipulated by the State of Florida, and information disclosed during office visits.

_____ (initial) BREVARD COSMETIC SURGERY GROUP is **not** permitted to share medical information with anyone other than myself, including test results, sensitive information as stipulated by the State of Florida, and information disclosed during office visits
except_____.

Persons authorized to receive my medical information (full name, relationship, and phone number):

NAME	RELATIONSHIP	PHONE NUMBER

You may notify me with test results, appointment reminders and other information regarding my health information as follows:

_____ Message on answering machine (Phone number _____)
_____ Message on work voicemail (Phone number _____)
_____ Message on cell phone (Phone number _____)
_____ Give message to the family member or significant other who answers the phone
_____ Email address_____

I understand and direct that this authorization will remain in effect until it is revoked by me in writing.

_____ _____
Patient – Print Name Signature

DOB:_____ Date:_____

This authorization is not valid for the request of printed copies of your medical records. You and only you (or your legal personal representative) must sign a Health Information Release Form to obtain copies of your medical records. This release will be updated annually. If circumstances change, please let the office know.

Medical History

Name:_____ Age:_____ Date:_____

☐Single / ☐Married / ☐Divorced / ☐Widowed Occupation:_____

Who referred you:_____ Primary Care Doctor: _____

Reason for Today's visit: _____

Habits: Smoking:---------- ☐No / ☐Yes if yes, number of packs per day? _____
Alcohol Use:---------- ☐No / ☐Yes if yes, amount of drinks per day? _____
Current Medications:-------- ☐No / ☐Yes if yes, list:_____

_____

_____

Allergies to Medicines:----- ☐No / ☐Yes - if yes, list:_____

_____

Street Drug Use:---------- ☐No / ☐Yes - if yes, list:_____

Personal History: Have you ever had:

☐ **I have no medical problems requiring treatment**

High Blood Pressure---------- ☐ Yes
Diabetes---------- ☐ Yes
Heart Attacks / M.I.'s---------- ☐ Yes
Heart Problems ---------- ☐ Yes
Cancer ---------- ☐ Yes
Strokes ---------- ☐ Yes
Kidney Disease or Failure------ ☐ Yes
Breathing Difficulty---------- ☐ Yes
Tuberculosis or TB ---------- ☐ Yes
Asthma ---------- ☐ Yes
Liver Disease ---------- ☐ Yes

Hepatitis---------- ☐ Yes
Anesthesia Problems---------- ☐ Yes
Arthritis ---------- ☐ Yes
Anemia or Low Blood Count----- ☐ Yes
Bleeding Problems---------- ☐ Yes
Epilepsy---------- ☐ Yes
MRSA Infections---------- ☐ Yes
Recurrent Infections---------- ☐ Yes
HIV Positive---------- ☐ Yes
AIDS---------- ☐ Yes
Other Medical Problems---------- ☐ Yes

Any Surgery you have had: Please list

1_____ 4_____ 7_____
2_____ 5_____ 8_____
3_____ 6_____ 9_____

Injuries: Please list

1_____ 2_____ 3_____

Family History: Has any blood relative had:

Cancer: ---------- ☐Yes if yes, who?_____
Diabetes: ----------☐Yes if yes, who?_____
Heart Trouble: ----------☐Yes if yes, who?_____
High Blood Pressure: ------☐Yes if yes, who?_____
Strokes: ----------☐Yes if yes, who?_____
Tuberculosis: ----------☐Yes if yes, who?_____
Trouble with Anesthesia: --☐Yes if yes, who?_____
Bleeding Problems: ---------☐Yes if yes, who?_____

******Continued on next page******

Review of systems

Do you now have or have you had problems during the last year with:

1- Frequent or severe headaches ---------- ☐ Yes
2- Blurred vision or any loss of vision---------- ☐ Yes
3- Dry or irritated eyes---------- ☐ Yes
4- Decreased or loss of hearing---------- ☐ Yes
5- Recurrent nose bleeds---------- ☐ Yes
6- Sinus trouble----------☐ Yes
7- Difficulty swallowing---------- ☐ Yes
8- Enlarged glands---------- ☐ Yes
9- Recurrent or persistent sores in the mouth-------- ☐ Yes
10- Chest pain or Angina---------- ☐ Yes
11- Coughed up blood---------- ☐ Yes
12- An abnormal EKG or Chest X-ray---------- ☐ Yes
13- Pain in the arms---------- ☐ Yes
14- Chronic or frequent coughs---------- ☐ Yes
15- Palpitations---------- ☐ Yes
16- Swelling of the ankles or fluid retention---------- ☐ Yes
17- Stomach or digestive problems---------- ☐ Yes
18- Vomited Blood---------- ☐ Yes
19- Blood in your stools---------- ☐ Yes
20- Blood in your urine or kidney problems---------- ☐ Yes
21- Chronic joint or bone pain---------- ☐ Yes
22- Muscle problems---------- ☐ Yes
23- Numbness, weakness or tingling---------- ☐Yes
24- Easy bruising or bleeding problems---------- ☐ Yes
25- Anemia or abnormal blood count---------- ☐Yes
26- (Females Only)

Are you pregnant now or possibly pregnant---------- ☐ Yes / ☐ No
Date of last period - _____
# of pregnancies - _____

☐ **I have none of the above symptoms or problems _____ (please initial)**

Current Height: _____Foot _____Inches

Current Weight: _____Lbs

Preferred Pharmacy:

Name of Pharmacy: _____

Location Road and Intersection _____

City _____ **Zip code** _____ **Phone # (if known)** _____