ANITA MANDAL, M.D. P.A.(11/12)

PATIENT INFORMATON

Patient Name: Last ________________________**First** __________________**M.I.**______**SS#** ____________________
Street Address ____________________________________ **City /St**________________________ **Zip**______________
Mailing Address____
Phone: Day(_______**)**_________________ **Evening(**_______**)**________________ **CELL(**________**)**__________________
Married **Single** **Divorced** **Widowed** **Occupation** ____________________ **Employer**____________________
Work Address______________________________________**City/St**____________________________**Zip** __________
Email address ______________________________@ ______________ **Date of Birth** _____/_____/_____

Nearest Relative NOT Living With You__________________________________**Relationship**___________________
Phone (_______**)**_________ **Address** ____
Emergency Contact___________________________**Relationship**_______________**Phone (**_______**)**____________
Address______________________________________**City/St**___________________________**Zip**____________
How Did You Hear About Us ____
Referral ___________________________ **Ad**_______________________________________
Internet Search ______________________ **Other** ____________________________________

A notice is posted in our waiting room regarding malpractice insurance. "Under Florida Law, physicians are generally either required to carry malpractice insurance or otherwise demonstrate financial responsibility to cover potential malpractice claims for medical malpractice. Your doctor has decided not to carry malpractice insurance. This is permitted under Florida Law subject to certain conditions. Florida Law imposes penalties against noninsured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice."

Full payment for ALL services is due prior to the time of service. Once payment is made, it is non-refundable. We do not participate in health insurance plans. For non-cosmetic services covered by health insurance, we may provide you CPT/ICD-9 codes as a one time courtesy only. All purchased products/items are non-refundable. Prior to scheduling any procedure or surgery, a non-refundable deposit is required. The remaining balance is due at least 10 business days prior to the procedure/surgery. If you cancel your procedure/surgery, all deposits are non-refundable. If you reschedule, there is an additional $100. You are responsible for all taxes on products & services. If taxes apply, they are NOT included in your quote. 48 hours notice is required to avoid a $90.00 no show/cancellation fee. For bad checks, a $25.00 fee plus the amount of the bad check to be paid in cash only is due within 72 hours of notice. For any payments owed to our office, you are responsible for all collection fees, interest, professional and legal fees as well as court costs incurred related to collection of payment.Preparation of reports/letters/documents by physician are not included in your treatment or office visit and are billed at $400/hour.

My above information is accurate and complete to the best of my knowledge. I agree to notify Dr. Mandal's office in writing of any changes within 24 hours. I understand and agree to abide by the above policies.

______________________ ________________________________ _____/_____/_____
PRINT Patient Name SIGNATURE (Patient/Legal Guardian) Today's Date

MANDAL PLASTIC SURGERY CENTER P.A.

CONFIDENTIAL MEDICAL HISTORY P. 1 OF 1 (rev. 1/6/16)

PLEASE CAREFULLY READ AND COMPLETELY ANSWER ALL INFORMATION PRIOR TO SEEING THE DOCTOR

Patient Name _______________________________________Age_________ Weight __ _______ Height ________

Check the specific concerns/ procedures you wish to discuss with Dr. Mandal

□Facelift □Minifacelift □Eyelid lift □Brow lift □Neck □Ear shaping □Nose □Chin □ Hollow Cheeks

□Lips □Neck Liposuction □Hair /Brow transplant □ Skin texture/Wrinkles □Scars/Moles □Botox

□Ultherapy skin tighening □ Infini Skin tightening □Brown spots □ Long Term Fillers: Bellafill

□ Temporary Fillers: Radiesse, Restylane, Belotero, Perlane, Sculptra, Voluma, Juvederm, Sculptra

□ SculpSure non-invasive fat reduction □Other____

Have you consulted with another cosmetic doctor about similar concerns? Y/N

What is your time frame for having your procedures? □weeks □ months □ one year □2 years

□other, please explain ____

Check ALL illnesses/symptoms you now have or have ever had in the past:

□reaction to anesthesia □easy bruising/bleeding/blood clotting disorders □diabetes □tuberculosis

□cancer □stroke □high blood pressure □high cholesterol □arthritis □cold sores □shingles

□asthma/bronchitis/pneumonia/lung problems □spine problems □kidney problems/bladder

□abnormal heart rhythm/pacemaker □coronary heart disease/heart attack/angina □psychiatric

□seizures/neurologic disease □glaucoma/dry eye syndrome □HIV/ AIDS □headache □fainting history

□mental illness/depression/anxiety/bipolar □hepatitis/gallstones/cirrhosis/liver disease □ thyroid

□ Other____ □OTHERWISE HEALTHY

Explain in detail all illnesses/symptoms checked above:____ _______

____

____

List all FAMILY MEMBERS with illnesses checked above (if none, write NONE):

____

____

List ALL COSMETIC or PLASTIC SURGERIES and YEAR performed (if none, write NONE):

____

____

____

List Any Injectable Fillers or Botox you have had____

List Any Lasers you have had ____

List ALL other MAJOR and MINOR surgeries and YEAR performed (if none, write NONE):

____

____

____

List ALL HOSPITALIZATIONS, YEAR hospitalized and reason (if none, write NONE):

____

____

____

CONFIDENTIAL MEDICAL HISTORY P. 1 OF 2 (rev. 1/4/16)

Have you ever consulted with a psychologist/psychiatrist? Y/N Please explain:

____

____

Have you ever been a smoker? Y/N packs/day_______ years smoked________ when did you stop? _________

Do you drink alcohol? Y/N What _________________________ How much per week? _________________

Do you use recreational drugs? Y/N Please specify____

List ALL allergies/side effects to products and medication AND the reaction you have (if none, write NONE)

____

____

____

List ALL OVER THE COUNTER MEDICINES, VITAMINS, HERBS (if none, write NONE)

____

____

____

List ALL PRESCRIPTION MEDICATIONS and the REASON for taking (if none, write NONE)

____

____

____

List ALL blood thinners i.e. aspirin, vitamin E, Coumadin (If none, write NONE)____________________________

Any problems with local anesthesia for dental /surgical procedures? Y/N Explain _________________________

Have you ever used Accutane for Acne? Y/N Explain ____

Do you have dry eyes, excess tearing, irritated eyes? Y/N Explain ______________________________________

Do you get cold sores? Y/N Where?_______________ What medication do you take for them?_____________

Any back or neck problems that prevent you from lying flat? Y/N Explain _________________________________

Do you have keloids or bad scars? Y/N Explain____

Do you require antibiotics before dental work or minor procedures? Y/N Explain ________________________

Are you allergic to lidocaine, xylocaine, surgical tape, latex? Y/N Explain ________________________________

Do you experience easy bleeding or bruising? Y/N Explain ____

Date of last physical exam _________ Was it normal? Y/N Date of last EKG ________ Was it normal? Y/N

Last Chest Xray _______ Was it normal? Y/N Last bloodwork ___/___/___ Was it normal? Y/N

Primary Care Doctor name & number____

List name, reason, date for all MEDICAL SPECIALISTS seen in the past 5 years (if none, write NONE)

1)____

2)____

3)____

4)____

5)____

The above information is true and accurate to the best of my knowledge. My medical history will be used to make important decisions about my medical care and I agree to notify my physician within 24 hours of any changes in my medical history. Patient Signature _____________________________ Date ____/____/____