MANDAL PLASTIC SURGERY CENTER, P.A. (R: 8/9/24)

PATIENT INFORMATON

Date of Birth _____/_____/_____ **Email address** _____@ _____
Patient Name: Last _____**First** _____**M.I.**_____**SS#** _____
Street Address _____ **City** _____**St**___ **Zip**_____
Mailing Address_____
Phone: Day(_____**)**_____**Evening(**_____**)**_____ **CELL(**_____**)**_____
☐**Married** ☐**Single** ☐**Divorced** ☐**Widowed** **How Did You Hear Of Us** _____
Occupation _____ **Employer**_____
Work Address_____**City/St**_____ **Zip** _____
Nearest Relative NOT Living With You_____ **Relation**_____ **Phone(**_____**)**_____
Address _____
Emergency Contact _____**Relationship**_____ **Phone (**_____**)**_____
Address_____**City/St**_____**Zip**_____

A notice is posted in our waiting room regarding malpractice insurance which states: "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 services that may be covered by health insurance, no CPT/ICD-9 codes will be provided. 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 or 20% fee rescheduling fee, whichever is greater. Tax, when applicable, is not included in your quote. You are responsible for all applicable taxes on products & services. 48 hours notice is required to avoid a $90.00 no show/cancellation fee. Payment can be made by credit or debit card (AMEX not accepted) or cash. All check payments must be written to Mandal Plastic Surgery Center, P. A. at least 2 weeks prior to service. For bad checks, a $25.00 fee plus the total amount of the bad check must be paid in cash within 72 hours of notifying you. For any payments owed to our office, you are responsible for all collection fees, interest, professional and legal fees and court costs related to collection of payment. The costs of preparing reports/letters/documents are not included in your office visit fees and are billed at $400/hour. I agree to have any dispute(s) regarding my previous, current and/or future services or treatments resolved through arbitration in Palm Beach County to comply with Florida law.

My legal name, mailing address, date of birth, email address and contact numbers that I provided are correct and accurate. I agree to notify the office, in writing, of any changes or updates in this information within 24 hours. I understand and agree to abide by the above office and financial 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 ____/____/____

MANDAL PLASTIC SURGERY CENTER, P.A.

2401 PGA Blvd., Suite 146

Palm Beach Gardens, FL 33410

CONSENT TO COMMUNICATE

Please check all ways below that you consent to allow us to communicate with you.

Primary Contact number (_____)_____-_____ ☐cell ☐ home ☐work

Secondary Contact number (_____)_____-_____ ☐cell ☐ home ☐work

Tertiary Contact number (_____)_____-_____ ☐cell ☐ home ☐work

Fax number (_____)_____-_____

Email address _____@_____

Mailing Address _____

I give authorization to communicate appointment reminders and any medical information through the following methods using the above info (Check all that apply). I understand that I can revoke this consent in the future but that request must be made in writing. I further understand that it is my responsibility to confirm that Mandal Plastic Surgery Center, P.A. receives any and all changes to this consent.

☐ Voicemail

☐ Text Message

☐ Leave Message with Another Person (list full name of other person(s):

_____

☐ Mail

☐ Fax

Print Patient Name _____ _____

Patient Signature _____

Date of Birth: _____/_____/_____