BREVARD COSMETIC SURGERY GROUP

BOARD CERTIFIED PLASTIC AND RECONSTRUCTIVE SURGERY

FRANK X. VENZARA MD   ROBERT L BASHORE MD

DAN DANIELS PA-C   JOAN THOMAS RE, FS

PATIENT INFORMATION

NAME:____ DATE:_________

DOB:_________________________ SEX: M F

RACE:__________ HISPANIC_____ NON-HISPANIC_____ LANGUAGE:____________

CELL PHONE:_______________________ HOME PHONE:__________________

EMAIL ADDRESS:____

PREFERRED METHOD OF CONTACT: **TEXT CELL HOME EMAIL**

ADDRESS: ____

CITY: _____________________________STATE:__________ ZIP:____________

HOW DID YOU HEAR ABOUT US? **EMAIL BLAST FACEBOOK INSTAGRAM**

MERRITT ISLAND NOW FRIEND/DOCTOR REFERRAL__________________________

EMPLOYER:____

EMERGENCY CONTACT

NAME:______________________ ________ PHONE:_________________________

RELATIONSHIP:____

PREFERRED PHARMACY

NAME OF PHARMACY:____

LOCATION ROAD AND INTERSECTION:____

CITY____________________ ZIP CODE____________ PHONE#_________________

BREVARD COSMETIC SURGERY GROUP

BOARD CERTIFIED PLASTIC AND RECONSTRUCTIVE SURGERY

FRANK X. VENZARA MD   ROBERT L BASHORE MD
DAN DANIELS PA-C   JOAN THOMAS RE, FS

INSURANCE COVERED PROCEDURES ONLY

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 INFORMATION

CARRIER:___________________ ID#__________________ GROUP#________________
INSURED (NAME ON CARD):____
RELATIONSHIP TO PATIENT: **SELF SPOUSE CHILD**

SECONDARY INSURANCE INFORMATION

CARRIER:___________________ ID#__________________ GROUP#________________
INSURED (NAME ON CARD):____
RELATIONSHIP TO PATIENT: **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 the Social Security Administration or it's intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be 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 claim to Medicare for payment.

PATIENT SIGNATURE_____________________________________ DATE_____________

PRIMARY (NON-MEDICARE) & SECONDARY INSURANCE:
I hereby authorize release of information necessary to file a claim with:______________ Company and assign benefits otherwise payable to me to Brevard Cosmetic Surgery group or Frank X. Venzara MD, Robert L Bashore MD or Dan Daniels PA-C as indicated on the claim.

PATIENT SIGNATURE:____________________________________ DATE:_____________

CONTINUED ON NEXT PAGE

FRANK X. VENZARA MD ROBERT L BASHORE MD
DAN DANIELS PA-C JOAN THOMAS RE, FS

INSURANCE COVERED PROCEDURES CONTINUED

PATIENT RESPONSIBILITY
I understand that 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, it is our policy to transfer your account to a collection agency as provided by the laws of the State of Florida.

I understand that Brevard Cosmetic Surgery Group's providers 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 of this office and are my responsibility.

PATIENT SIGNATURE:_________________________________ DATE:___________

PARENT/GUARDIAN:__________________________________ DATE:___________

BREVARD COSMETIC SURGERY GROUP

BOARD CERTIFIED PLASTIC AND RECONSTRUCTIVE SURGERY

FRANK X. VENZARA MD ROBERT L BASHORE MD

DAN DANIELS PA-C JOAN THOMAS RE, FS

MEDICAL HISTORY

NAME:______________________________ AGE:________ DATE:____________

HEIGHT: __________ FEET ___________ INCHES WEIGHT:__________LB

PRIMARY CARE DOCTOR:______________________________ PATIENT INS: __________

DERMATOLOGIST:____

REASON FOR TODAY'S VISIT:____

ALLERGIES TO MEDICINE: YES NO

IF YES, LIST:____

MEDICATIONS (LIST NAME AND DOSE, INCLUDE HERBAL, SUPPLEMENTS, VITAMIN)

____

____

REVIEW OF SYMPTOMS (WITHIN THE LAST YEAR)

HEADACHES	**YES**	DIZZINESS	**YES**
BLURRED VISION	**YES**	DRY EYES	**YES**
LOSS OF HEARING	**YES**	NOSE BLEEDS	**YES**
DIFFICULTY SWALLOWING	**YES**	RECURRENT MOUTH SORES	**YES**
ENLARGED GLANDS	**YES**	CHEST PAIN	**YES**
SHORTNESS OF BREATH	**YES**	PALPITATIONS	**YES**
CHRONIC COUGH	**YES**	WHEEZING	**YES**
ABNORMAL EKG	**YES**	ABNORMAL CHEST X-RAY	**YES**
SWELLING IN ANKLES/FEET	**YES**	ANEMIA	**YES**
NAUSEA/VOMITING	**YES**	STOMACH PAIN	**YES**
BLOOD IN STOOLS	**YES**	BLOOD IN URINE	**YES**
CHRONIC JOINT PAIN	**YES**	MUSCLE WEAKNESS	**YES**
NUMBNESS OR TINGLING	**YES**	BRUISING EASILY	**YES**

**** I HAVE HAD NONE OF THESE SYMPTOMS ___________(PLEASE INITIAL)****

MEDICAL HISTORY CONTINUED

SOCIAL HISTORY

MARITAL STATUS____

NICOTINE USE: **NO** **YES** CIGARETTES TOBACCO CHEW GUM PATCH

PACKS/AMOUNT PER DAY______ # OF YEARS______ FORMER SMOKER? **NO** **YES**

STREET DRUG USE: **NO** **YES** PLEASE LIST:_____________________

DAILY ALCOHOL USE: **NO** **YES** NUMBER OF DRINKS PER DAY:_______

OCCUPATION: ____

FAMILY HISTORY

STROKE	YES	NO	WHO:__________________________________
HEART DISEASE	YES	NO	WHO:__________________________________
HIGH BLOOD PRESSURE	YES	NO	WHO:__________________________________
DIABETES	YES	NO	WHO:__________________________________
CANCER	YES	NO	WHO:__________________________________
ANESTHESIA PROBLEMS	YES	NO	WHO:__________________________________
BLEEDING PROBLEMS	YES	NO	WHO:__________________________________

PAST MEDICAL HISTORY

TIA/STROKE	YES	NO	PANCREATITIS	YES	NO
ANESTHESIA PROBLEMS	YES	NO	HEPATITIS	YES	NO
EPILEPSY	YES	NO	LIVER DISEASE	YES	NO
HIGH BLOOD PRESSURE	YES	N0	ARTHRITIS	YES	NO
HIGH CHOLESTEROL	YES	NO	ANEMIA	YES	NO
HEART ATTACK	YES	NO	RECURRENT INFECTION	YES	NO
AUTOIMMUNE DISEASE	YES	NO	HIV/AIDS	YES	NO
ASTHMA	YES	NO	DVT	YES	NO
HEART PROBLEMS	YES	NO	BLEEDING PROBLEMS	YES	NO
PULMONARY EMBOLISM	YES	NO	CANCER	YES	NO
KIDNEY DISEASE	YES	NO	HERPES/COLD SORE	YES	NO

OTHER MEDICAL PROBLEMS (PLEASE LIST)___________________________________

PAST SURGICAL HISTORY

1_______________________	4_____________________	7______________________
2_______________________	5_____________________	8______________________
3_______________________	6_____________________	9______________________

FEMALES ONLY:

ARE YOU PREGNANT NOW OR POSSIBLY PREGNANT? **YES** **NO**

DATE OF LAST PERIOD______________________

OF PREGNANCIES________________________

BREVARD COSMETIC SURGERY GROUP

BOARD CERTIFIED PLASTIC AND RECONSTRUCTIVE SURGERY

FRANK X. VENZARA MD   ROBERT L BASHORE MD
DAN DANIELS PA-C   JOAN THOMAS RE, FS

HIPAA: PRIVACY ACT INFORMATION

I_________________________________ACKOWLEDGE THAT I HAVE RECEIVED A COPY OF THE PRIVACY ACT FOR DR. VENZARA, DR. BASHORE, DAN DANIELS PA-C AND JOAN THOMAS RE, FS. I ALSO ACKNOWLEDGE BEING MADE AWARE THAT A COPY OF MY PRIVACY RIGHTS IS POSTED IN THE WAITING ROOM OF BREVARD COSMETIC SURGERY GROUP. A COPY OF SAID RIGHTS IS AVAILABLE TO ME AT MY REQUEST.

PATIENT SIGNATURE:________________________________   DATE:____________

HIPAA CONTACT INFORMATION

In order to assist you in receiving your health information from Brevard Cosmetic Surgery Group, please complete the following information.

_______(Initial) BREVARD COSMETIC SURGERY GROUP is permitted to share **ANY AND ALL** medical information with the individuals listed below. This includes 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. This includes test results, sensitive information, as stipulated by the State of Florida, and information disclosed during office visits.

Persons authorized to receive my medical information: (Include full name, phone, relationship)
1.____
2.____

You may notify me with test results, appointment reminders and other information regarding my health information as follows:
_____ Message on home phone   _____ Message on cell phone
_____ Give message to person listed above   _____ Email

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

__________________________________   _________________
Patient Signature   Date

This authorization is NOT valid for the request of printed copies of you medical records

BREVARD COSMETIC SURGERY GROUP

BOARD CERTIFIED PLASTIC AND RECONSTRUCTIVE SURGERY

FRANK X. VENZARA MD   ROBERT L BASHORE MD

DAN DANIELS PA-C   JOAN THOMAS RE, FS

COVID-19 QUESTIONNAIRE

Do you have or have you had any of these symptoms in the last 2 (two) weeks?

- ☐ Cough (RECENT ONSET)
- ☐ Shortness Of Breath

OR DO YOU HAVE AT LEAST 2 OF THESE SYMPTOMS?

Fever	Sore Throat	Headache
Chills	New Loss of Taste or smell	Diarrhea
Muscle Pain	Vomiting	

Have you or anyone in your household been exposed to COVID-19 in the last 2 weeks?

- ☐ YES
- ☐ NO

Have you or anyone in your household been tested for COVID-19 in the last 2 weeks?

- ☐ YES
- ☐ NO

Have you or anyone in your household been tested for COVID-19 in the past 2 weeks?

- ☐ YES
- ☐ NO

Have you or anyone in your household been out of the state of Florida in the last 2 weeks?

- ☐ YES
- ☐ NO

IF YOU HAVE ANSWERED YES TO ANY OF THESE QUESTIONS, YOU WILL BE REFERRED FOR COVID TESTING AND YOUR PROCEDURE WILL BE POSTPONED UNTIL WE HAVE A NEGATIVE TEST RESULT

NAME:____

SIGNATURE: ____

DATE & TIME:____

WITNESS:____