



MICHAEL DIAZ, M.D., F.A.C.S.
BOARD CERTIFIED PLASTIC SURGEON

936 Tommy Munro Dr. • Biloxi, MS 39532 Phone: 228-396-2663 • Fax: 228-396-2664

Date

Reason for visit Today: (Please include topic, be as specific as possible) _____

PERSONAL INFORMATION:

Name: _____ Sex: Male Female

Address: _____

City: _____ State: _____ Zip Code: _____

Social Security # _____ Date of Birth: _____

Home Phone _____ Cell Phone _____ Work Phone _____

E-mail Address: _____

Employer: _____ Occupation: _____

Check one: Single Married Separated Divorced Widowed Other

Spouse/Significant Other's Name: _____

Employer: _____ Occupation: _____

Work Phone: _____ Spouse Date of Birth: _____

Emergency Contact:

Name: _____ Phone: _____ Relationship: _____

Employer: _____ Occupation: _____

Family Physician:

Name: _____ Phone _____

Address: _____ City: _____ State: _____ Zip Code: _____

Date of Last Physical Exam: _____


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Insurance:

Insurance Holder Name: _____

Date of Birth (if different from patient): _____

Social Security Number (if different from patient): _____

MEDICAL INFORMATION:

We are here to help you. Please answer as truthfully and completely as possible. Do you have:

- | | | | |
|----------------------------|--|----------------------------------|--|
| Heart Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Bulimia or Anorexia | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Autoimmune Disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hormone Replacement Therapy | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma or COPD | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mental Illness | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Lung Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Drug Dependency | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| CPAP Machine | <input type="checkbox"/> Yes <input type="checkbox"/> No | Depression | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Sleep Apnea | <input type="checkbox"/> Yes <input type="checkbox"/> No | Environmental Allergies | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Serious Accident | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood or Bleeding Disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Problem with general anesthesia | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Latex Allergies | <input type="checkbox"/> Yes <input type="checkbox"/> No | Chronic Illness | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Birth Control | <input type="checkbox"/> Yes <input type="checkbox"/> No | Previous/Current Serious Illness | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hepatitis C | <input type="checkbox"/> Yes <input type="checkbox"/> No | HIV | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Type: _____ Other: _____

If you answered **YES** to any of the above, please explain:

Please list **ALL** previous surgeries, **including** Cosmetic Procedures:

OPERATION	YEAR	HOSPITAL	SURGEON	TYPE OF ANESTHESIA

If you have had any Cosmetic Procedures, were you happy with the outcome? Yes No


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Have you had any cardiac testing done? Yes No Please list cardiologist, location and date of test:

FAMILY HISTORY: Has any family member had any of the following?

		Affected Family Member	Notes
No Relevant Family History	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Unknown / Adopted	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Autoimmune Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Hemophilia / Blood or Bleeding Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No		
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Lung or Respiratory Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Problem with General Anesthesia	<input type="checkbox"/> Yes <input type="checkbox"/> No		

LIFESTYLE:

Have you taken diet pills/injections or been on a diet in the last 3 years? Yes No

Do you take Adipex (Phentermine)? Yes No Date last taken? _____

Height: _____ Weight: _____

Do you exercise? Yes No Activity: _____ How often? _____

(You must stop taking Adipex(Phentermine) at least 2 weeks prior to surgery.)

Alcohol Consumption:

How many drinks containing alcohol do you drink a week? _____ day/week

How often do you take Aspirin, Ibuprofen, Advil, Aleve or Naproxen on a regular basis? Daily Weekly
 Rarely Weekly

Smoking:

Do you smoke (cigarettes, cigars or e-cigs)? Yes No Packs per day: _____

Number of years: _____ Have you quit smoking? Yes No When? _____

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Are you **ALLERGIC** to any medications? Yes No

If yes, please list:

Medication: _____ Reaction: _____
Medication: _____ Reaction: _____
Medication: _____ Reaction: _____

Do you take anti-depressants? Yes No If **YES**, physician prescribing them: _____

Please list **ALL MEDICATIONS** and the physician who is prescribing them:

PREFERRED PHARMACY:

Name: _____ Location: _____

List **ALL OVER THE COUNTER MEDICATIONS, INCLUDING VITAMINS & HERBAL SUPPLEMENTS, which you take regularly:**

CHILDBIRTH:

Number of pregnancies: _____ How much weight did you gain with each pregnancy? _____

Number of children: _____ Age(s) of children: _____ Did you breastfeed? Yes No

Have you stopped breastfeeding? Yes No

EYES:

Do you wear contacts? Yes No Glasses? Yes No Do you suffer from dry-eye? Yes No

Who is your ophthalmologist?

How did you hear about Dr. Diaz? _____ May we thank them for referral? Yes No

Patient Signature

Date

Patient Consent Form

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I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.
- Release pertinent information to assist the practice with medical authorization and financial support if there's a challenge to payment. This can include health care expenses; which include medical insurance, banking, finance companies and credit card companies.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____ Date: _____

Signature: _____

Relationship to Patient: _____

AUTHORIZATION

- I. GENERAL CONSENT TO TREATMENT:** I AGREE AND CONSENT TO A PHYSICAL EXAMINATION BY **MICHAEL DIAZ, M.D.** FOR AESTHETIC AND GENERAL PLASTIC SURGERY CONSULTATION BY DR. MICHAEL DIAZ AND/OR HIS ASSOCIATES. I UNDERSTAND THAT ADDITIONAL DIAGNOSTIC PROCEDURES AND TREATMENT MAY BE RECOMMENDED BY THE PHYSICIAN AND WILL BE DISCUSSED WITH ME BEFORE BEING DONE. I ACKNOWLEDGE THAT THERE ARE NO GUARANTEES, EXPRESSED OR IMPLIED, AS TO THE RESULTS OF ANY PROCEDURES OR MEDICAL TREATMENT PERFORMED.
- II. RELEASE OF INFORMATION:** I AUTHORIZE PHYSICIANS PROVIDING SERVICES ON BEHALF OF THE PATIENT TO RELEASE ALL BILLING AND MEDICAL INFORMATION (INCLUDING INFORMATION CONCERNING SUBSTANCE ABUSE AND HIV STATUS, IF APPLICABLE) TO PHYSICIANS OR INSTITUTIONS PROVIDING FOLLOW-UP CARE, THE SOCIAL SECURITY ADMINISTRATION, MEDICARE, MEDICAID (OR THEIR VARIOUS INTERMEDIARIES), AND THE INSURANCE COMPANY, EMPLOYER, PERSON ACTING ON BEHALF OF A PREFERRED PROVIDER ARRANGEMENT OR THIRD PARTY NAMED ON THIS PATIENT INFORMATION FORM (OR ANY OF THEIR AGENTS OR REPRESENTATIVES), WHEN SUCH INFORMATION IS REQUIRED FOR PAYMENT, WORKERS' COMPENSATION, UTILIZATION REVIEW, OR COVERAGE DETERMINATION PURPOSES. I UNDERSTAND THAT THIS AUTHORIZATION WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING AND DELIVERED TO THIS PHYSICIAN'S OFFICE.
- III. ASSIGNMENT OF INSURANCE OR THIRD PARTY COVERAGE:**
- A. I AUTHORIZE ANY THIRD PARTY PAYOR TO PAY DIRECTLY TO THE PHYSICIAN PROVIDING SERVICES TO THE PATIENT, ALL BENEFITS DUE PAYABLE AS A RESULT OF SERVICES RENDERED.
- B. I AUTHORIZE ASSIGNMENT TO THE PHYSICIAN WHO HAS PROVIDED SERVICES TO THE PATIENT THE INSURED'S RIGHTS TO PENALTIES AND ATTORNEY'S FEES IN THE EVENT THAT THE INSURER FAILS TO TIMELY PAY SUCH BENEFITS IN ACCORDANCE WITH MISSISSIPPI LAW.
- IV. ACKNOWLEDGEMENT OF RESPONSIBILITY TO PAY FOR SERVICES:**
- I ACKNOWLEDGE AND AGREE THAT, EXCEPT AS PROVIDED BY LAW, AND IN CONSIDERATION OF THE SERVICES PROVIDED, I WILL PAY ANY CHARGES WHICH, FOR ANY REASON, ARE NOT PAID BY ANY THIRD PARTY PAYOR UNLESS THERE IS A SPECIFIC WRITTEN AGREEMENT BETWEEN THE PHYSICIAN AND THE PATIENT OR BETWEEN THE PHYSICIAN AND THE PAYOR. I ACKNOWLEDGE THAT THIS FEE IS INCURRED ON OPEN ACCOUNT FOR PROFESSIONAL MEDICAL SERVICES. I ACKNOWLEDGE THAT IF I FAIL TO PAY THE BALANCE DUE ON THIS OPEN ACCOUNT WITHIN THIRTY (30) DAYS AFTER WRITTEN DEMAND, AND IN THE EVENT JUDGEMENT IS RENDERED AGAINST ME, IN ADDITION TO THE PRINCIPAL BALANCE DUE, I SHALL BE LIABLE FOR REASONABLE ATTORNEY FEES, LEGAL INTEREST FROM DATE OF JUDICIAL DEMAND, UNTIL PAID, PLUS COSTS OF COURT.
- V. MEDICARE PATIENTS:**
- I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE PAYABLE TO **MICHAEL DIAZ, M.D.**, FOR ANY SERVICES FURNISHED ME BY DR. MICHAEL DIAZ AND/OR HIS ASSOCIATES. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO BE RELEASED TO THE HEALTHCARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

DATE

SIGNATURE



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Audio / Visual / Website Authorization for Healthcare Education

Print Name

The undersigned does hereby authorize Dr. Michael Diaz, his agents or employees or other persons to photograph, make moving sound pictures, videotapes, disc, or audiotapes of the above-named patient while under the care of Dr. Michael Diaz, and agrees that Dr. Michael Diaz, his agents or employees or other persons may use negatives, discs, prints, videotapes, or audiotapes prepared therefrom for research, teaching, or publication, or other purposes including use on a website, for the education of patients and healthcare practitioners.

This consent is subject to revocation at any time except to the extent the action has been taken thereon.

Your healthcare (or payment for healthcare) will not be affected by whether or not you sign this authorization. Once your healthcare information is released, re-disclosure of your healthcare information by any recipient may no longer be protected by federal law.

Signature of Patient/Legal Guardian

Printed Name

Date

Relationship (if not patient)

I hereby grant permission for the use of any of my medical records, including illustrations, photographs or other records created in my case, for use in examination, testing, credentialing and/or certifying purposes by The American Board of Plastic Surgery, Inc.

Signature of Patient

Signature of Witness

Date



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Dear Valued Patient,

We here at Michael Diaz, MD, FACS have been asked to accept many different insurance policies. We accept their promise to pay when you present an insurance care, however, you will be ultimately responsible for any amount that your insurance company does not pay. Please note that it is your responsibility to know your insurance benefits.

The benefits offered by many insurance companies vary depending on which doctor you see, whether the insurance company is primary or secondary and /or various other combinations. You will be responsible for the balance if your insurance company does not pay.

We encourage you to verify coverage with your own insurance prior to being seen.

We do agree to bill your insurance for you only as a courtesy. If they do not pay within a reasonable period of time we will expect you to pay us and deal with the insurance company yourself.

I have read and agree and understand that I am ultimately liable for the services that I receive. If for any reason, my insurance does not pay for my services, I agree to pay Michael Diaz, MD directly and will not hold your staff, including receptionists, Doctor's, or telephone operators responsible for my insurance company not paying my bills.

CREDIT CARD PAID SERVICES:

Services that are performed that are paid with a credit card, debit card, or financing third party are not eligible for payment challenges after services are provided. By signing this form, I am irrevocably consenting to allow Michael Diaz, MD, FACS to use and disclose my protected health information to any Credit Card Entity, Bank or Financing Company when they request such information to process an account and assist with payment. I agree that this non credit card challenge agreement is irrevocable.

Patient's Signature

Date Signed