



PLASTIC • COSMETIC • RECONSTRUCTIVE SURGERY

Cambridge Professional Center • 3500 Old Washington Road, Suite 201 • Waldorf, MD 20603

(301)870-0600 • FAX (301)870-0609 • Email: Fontanaplsurg@aol.com

www.fontanacosmeticsurgery.com

**Patient Information**

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Male  Female

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Marital Status  Single  Married  Divorced  Widowed  Separated

Age \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Home Phone # (\_\_\_\_)\_\_\_\_ - \_\_\_\_

Home Address \_\_\_\_\_

Cell Phone # (\_\_\_\_)\_\_\_\_ - \_\_\_\_

(city) \_\_\_\_\_ (state) \_\_\_\_\_ (zip code) \_\_\_\_\_

Work Phone # (\_\_\_\_)\_\_\_\_ - \_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Email address \_\_\_\_\_

Referred by  Dr. \_\_\_\_\_  Internet  
 Friend \_\_\_\_\_  Other \_\_\_\_\_

**Emergency Contact**

Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Home Phone # (\_\_\_\_)\_\_\_\_ - \_\_\_\_ Cell Phone # (\_\_\_\_)\_\_\_\_ - \_\_\_\_

**Personal Health History**

Primary Care Physician \_\_\_\_\_ Phone Number \_\_\_\_\_

**Medical Problems (Past and Present)**

- Abnormal Bleeding  Yes  No
- Allergies  Yes  No
- Anemia  Yes  No
- Arthritis  Yes  No
- Asthma  Yes  No
- Cancer \_\_\_\_\_  Yes  No
  - ▶ Chemotherapy  Yes  No
  - ▶ Radiation  Yes  No
- Cold Sores  Yes  No
- Diabetes  Yes  No
- Headaches  Yes  No
- Heart Disease  Yes  No
- Hepatitis  Yes  No
- HIV  Yes  No
- High Blood Pressure  Yes  No
- Migraines  Yes  No
- Seizures  Yes  No
- Stroke  Yes  No
- Thyroid Problems  Yes  No
- Other \_\_\_\_\_

**Pregnancies:**

Year \_\_\_\_\_  
\_\_\_\_\_

**Previous Surgeries**

Year \_\_\_\_\_ Reason \_\_\_\_\_  
\_\_\_\_\_

**Other Hospitalizations**

Year \_\_\_\_\_ Reason \_\_\_\_\_  
\_\_\_\_\_

**Medications: Prescriptions and Over-the-Counter Allergies**

Drug	Strength	Frequency Taken	Previous reaction to anesthesia <input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	▶ Describe: _____
_____	_____	_____	Are you allergic to latex? <input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	Are you allergic to any medications? <input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	Drug                      Reaction
_____	_____	_____	_____
Do you take aspirin? <input type="checkbox"/> Yes <input type="checkbox"/> No _____			_____
Do you take ibuprofen? <input type="checkbox"/> Yes <input type="checkbox"/> No _____ (Advil, Motrin, Nuprin)			_____

**Social History**

Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No	For current smokers: I understand that smoking
Do you currently smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No	affects the blood supply to my tissues, which places
If yes, how much? _____ Day	me at increased risk for prolonged wound healing,
Have you smoked in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No	blistering, and/or actual skin and tissue loss.
Do you use recreational drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No	Signature x _____

**Family History**

	Age(s)	Significant Health Problems	
▶ Father	_____	_____	Has anyone in the family had any problems with anesthesia? <input type="checkbox"/> Yes <input type="checkbox"/> No
▶ Mother	_____	_____	
▶ Siblings	_____	_____	Has anyone in the family had unusual bleeding with surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No
▶ Children	_____	_____	

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature x \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Consent and Simplified Adult Release for Photographs**

I understand that photographs are an objective measure used to evaluate a patient's condition. I consent to have my photographs taken by Don J. Fontana, M.D. PA for the purpose of medical documentation, patient education, and insurance verification in cases of reconstructive procedures.

I also understand that with my consent, I grant Dr. Fontana the permission to publish the same in whole or in part for illustration or promotion in any media.

Signature x \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## Request for Confidential Handling of Health Information

Name: \_\_\_\_\_  
Last First MI

Date of Birth: \_\_\_\_\_  
MM/DD/YYYY

The following individual is involved in my health care. I give Don J. Fontana, M.D. PA permission to communicate with the person listed below as needed for my ongoing health care activities. If you wish to name more than one person, please attach a separate sheet listing the additional individual (s).

Name: \_\_\_\_\_  
Last First MI

Primary Phone: \_\_\_\_\_ Secondary Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_

Don J. Fontana, M.D. PA will acknowledge the individual you have named above as being involved in your health care activities until you notify us in writing of your intention to retract this permission. This notification is not intended as a replacement for an authorization to release protected health information. In the event the amount of information to be conveyed exceeds the minimal amount necessary for involvement in your ongoing health care activities, you or your personal representative must complete a valid authorization of release of information.

**I request the confidential handling of my health information as indicated above.**

\_\_\_\_\_  
**Printed Name of Patient or Authorized Representative**

\_\_\_\_\_  
**Relationship**

X \_\_\_\_\_  
**Signature of Patient or Authorized Representative**

\_\_\_\_\_  
**Date**

**Your request will remain in effect until you notify Don J. Fontana, M.D. PA in writing of your intention to terminate or modify this request for confidential handling of your health information.**