Northeast Florida Plastic Surgery Center
New Patient Information Form

(Please Print)

Appt Date:

Patient Information:

Last Name:	Home Phone:
First Name:	Cell Phone:
Address:	Date of Birth:
	E-mail:
Employer/School:	Occupation:

Who May We Thank For Referring You? ***Procedure Interested In:***

Insurance Information:

Primary Ins:	Secondary Ins:
ID #	ID #
Phone #	Phone #
Sponsor Name:	Sponsor Name:
Relationship to Patient:	Relationship to Patient:

Emergency Contact:

Name:	Phone:

- I hereby authorize the release of any information required in the course of my examination or treatment.
- I hereby authorize payment of medical benefits directly to ERIC A. WEISS, M.D.
- I understand that I am financially responsible for charges not covered by my insurance.
- I understand that payment is due at the time of service unless previous arrangements have been made.

Signature_____ Date _____

MEDICAL/SURGICAL HISTORY

Patient Name:
Patient No.:

Today's Date:
Surgery Date:
Surgeon Name: **Eric A. Weiss, M.D., F.A.C.S.**

Procedures:

In this time of rapidly expanding medical knowledge and the increasing specialization associated therewith, there exists a very real risk of the specialist physician not being aware of the general health and medical background of the patient. On occasion such information may critically affect what procedures we may safely undertake on you and under what circumstances. We therefore ask that you give us the following medical information.

Age: Height: Weight: Occupation:

Please list all medications which you are currently taking or have used in the past 6 months (be sure to include any of the following: birth control pills, aspirin or ibuprofen containing drugs, diet pills, diabetic medications, steroids, glaucoma drops, asthma medications, Digoxin, Lanoxin, nitroglycerin, Isordil, Inderal, other heart medications, Lasix, other diuretics, high blood pressure medications, Coumadin, Persantine, tranquilizers, sleeping pills, anti-depressants, pain pills or shots, epilepsy medications).

Medication(s): Amount Frequency

List all drug allergies:

Have you ever used (circle): LSD/speed/cocaine/marijuana? Never

Are you a smoker? YES/NO Ex-Smoker YES/NO Non-Smoker YES/NO

How much are (were) you smoking? How long? Quit how long ago?

How much alcohol do you drink? Caffeine?

Please circle all of the following medical conditions you now have or have had in the past:
bleeding tendency / hepatitis / diabetes / blood transfusions / high blood pressure / glaucoma / dry eyes / skin problems / lung disease / TB / asthma or wheezing / emphysema / bronchitis / irregular heart beat / chest pain / heart disease / heart attack / stroke / epilepsy / heart burn / intestinal ulcers or bleeding / depression / mental illness / drug or alcohol addiction / any other serious illness or injury / None of the above

Is there any possibility that you may be pregnant at this time? YES/NO

List all surgeries that you have had (include plastic surgery): Date:

Have you or anyone in your family ever had unusual reactions to anesthesia (muscle weakness, jaundice, breathing problems or unexpected fevers? YES/NO

Do you have (circle): loose or chipped teeth/caps/dentures/contact lenses/None

Have you ever seen a cardiologist? YES/NO Physician Name:

Date of last EKG: Date of last Mammogram:

Family history of breast cancer?

Patient's Signature:

Date:

AUTHORIZATION FOR EXAMINATION

AUTHORIZATION

TREATMENT: I,_____, represent to the physicians and staff that I am at least 18(eighteen) years of age or, if not, am accompanied by a legal guardian. I hereby consent to and authorize examination and treatment by Dr. Weiss and such assistant or staff as may be assigned by him.

MEDICAL INFORMATION: I authorize the release of any medical information for the purpose of processing insurance claims on my behalf. I authorize payment of medical benefits directly to the doctor for services provided to me. A copy of this authorization shall be considered as valid as the original.

PHOTOGRAPHS I understand that photography is a necessary part of planning and evaluating cosmetic or reconstructive surgery. I authorize the taking of photographs at the direction of Dr. Weiss and under such conditions as may be approved by him. These photographs will be used solely for documentation purposes unless further consent is given.

I hereby give permission to use my photographs for patient and public education or any other purpose which Dr. Weiss deems proper. This may include the use of them on our website or other social media platforms. My name will not be used in any case. Unless the procedures or issues specifically involves the face and/or neck, I understand that my face will not be shown in photographs, and any distinguishing marks such as tattoos, birthmarks, etc. will be covered. I relinquish any rights, title, or interest in these photographs.
INT:_____

ARBITRATION: In the event of any litigation arising out of or relating to the rendition of services by Dr. Eric Weiss, Northeast Florida Plastic Surgery, LifeStyle Lift or any of its agents or employees (collectively, the"Provider"), this Agreement, or any breach of any duty or obligation arising out of or relating thereto, Patient irrevocably and knowingly agrees to submit all matters to resolution by arbitration in accordance with the commercial arbitration rules of the American Arbitration Association (AAA). All parties expressly waive any challenge to the use of arbitration in accordance with this paragraph. The arbitration shall take place in Clay County, Florida. The arbitrator shall have no jurisdiction to award punitive damages or attorneys' fees. The parties hereto agree that jurisdiction and venue of the entry of judgement of the arbitrator shall be in Clay County, Florida. The arbitrator is directed to award the expenses of the arbitration, including required travel and other expenses of the arbitrator and the costs and charges of the American Arbitration Association to the prevailing party in the arbitration. Each party hereto hereby knowingly, voluntarily and intentionally elects arbitration and thereby waives the right to a trial by jury with respect to any controversy or claim based, directly or indirectly, heron, or arising out of, under or in connection with the transactions contemplated by this Agreement and any course of conduct, course of dealing, statements (whether verbal or written) or actions of the parties hereto. This provision is a material inducement for the Provider to enter into this Agreement.

SIGNATURE:_____DATE:_____
RELATIONSHIP TO PATIENT: PATIENT SPOUSE PARENT GUARDIAN

Eric Weiss, M.D., F.A.C.S.

. . . . . .

(904) 215-5800

Eric A. Weiss M.D.
Board Certified Plastic
Reconstructive
Surgeon

AMERICAN SOCIETY OF
PLASTIC AND RECONSTRUCTIVE
SURGEONS, INC

NorthEast Florida Plastic Surgery Center

AUTHORIZATION FOR RELEASE OF INFORMATION

TO:_____

_____
(DOCTOR OR HOSPITAL)

I hereby request and authorize that you release:

Any Medical Records in your possession, concerning:

_____

Patient: _____

Date Of Birth: _____

Social Security #: _____

Signature: _____

This disclosure is authorized for the purpose of consultation and/or treatment. Send to:

Dr. Eric A. Weiss., M.D.
421 Kingsley Ave. Bldg 200
Orange Park, FL 32073
(904) 215-1211 (fax)

I authorize Dr. Weiss to include my record in a peer review as he deems necessary.

Signature of Patient_____ Date_____

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I, _____ hereby consent to the use or disclosure of my protected health information by the practice of Eric A. Weiss, M.D., F.A.C.S., hereinafter referred to as ("Practice") for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me by Dr. Weiss may be conditioned upon my consent as evidenced by my signature on this document.

I also understand that I have the right to request restrictions as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. The practice is not required to agree to these restrictions, which I may request. However, if the practice agrees to the restrictions that I request, the restriction is binding on the practice and Dr. Weiss.

I have the right to revoke this consent, at any time, in writing, except to the extent that Dr. Weiss or the practice has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by Dr. Weiss, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review the practice's Notice of Privacy Practices, which has been provided to me by the practice, prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operation. This Notice of Privacy Practices also describes my rights and the practice's duties with respect to my protected health information. The Notice of Privacy Practices for the practice is also provided at 421 Kingsley Avenue Suite 200, Orange Park, FL 32073.

As provided in our notice, the terms of our notice may change. If changes are made, I may obtain a revised Notice of Privacy Practices by calling your office and requesting a revised copy be sent in the mail or by requesting one at the time of my next appointment.

_____

Signature of Patient or Personal Representative

_____

Printed Name of Patient or Personal Representative

_____ _____

Description of Personal Representative's Authority Date