Pope Plastic Surgery

Patient Information

Patient Name: _____
Last First Middle

Date of birth _____ Age _____ Sex _____

Street address _____ City _____ State _____ Zip _____

Mailing address _____ City _____ State _____ Zip _____

Cell phone _____ Work phone _____

Employer _____ Address _____

Driver's License # _____ State of Issue _____

E-mail address _____

❑ Check if you would not like to receive promotional information from us

Parent or Spouse Information

Name _____ Relationship _____

Mailing address (if different from patient) _____ City _____ State _____ Zip _____

Cell phone _____ Work phone _____

Referral information

Referred by _____ Address _____

Phone _____ May we thank them for referring you? ❑ Yes ❑ No

Did you hear about us in any of the following media? ❑ Orlando Magazine ❑ Watermark ❑ Billboards
❑ Internet Search Engine ❑ Other _____

What is the reason for today's visit? _____

Have you been treated elsewhere for this? ❑ No ❑ Yes If so, by whom? _____

Name/Address of Primary Care Physician _____

_____

Medical Records Release

Do you authorize the release of medical records to:

Primary care doctor? ❑ Yes ❑ No Signature _____ Date _____

Referring doctor? ❑ Yes ❑ No Signature _____ Date _____

Emergency Contact

Name _____ Address _____

Phone _____ Relationship to you _____

Fees

I understand I am responsible for all fees for services provided by Dr. Pope and his staff I agree to pay for all services.

Signature _____ Date _____

Cancellation Policy

To provide our patients the best care, we require a 24-hour advance notice if you are unable to keep your appointment.
I understand the importance of keeping my scheduled appointment and I agree to notify the office 24 hours in advance if I am unable to keep my appointment. I also understand and agree I will be charged $50 if I do not give the required notice.

Signature _____ Date _____

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Communication Use & Disclosure Authorization

Please complete the following information for all requests:

Patient name _____

Date of birth _____ Patient #_____

Address _____

I hereby request the following regarding the use of my personal health information:

1. You may leave the following information on answering machines or voice mail

- ❑ Referral information
- ❑ Prescription refill information
- ❑ Test results
- ❑ Appointment information
- ❑ Brilliant Distinctions information
- ❑ Other:

2. You may discuss information and care with the following family members and/or friends:

_____

_____

_____

_____

3. You may contact me regarding my treatment and care at the following numbers:

_____

_____

Signature of Patient or Guardian _____ Date _____

Signature & Title of Staff Person _____

Printed Name & Title of Staff Person _____

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Acknowledgment of Receipt of Privacy Practices

The undersigned patient or legally authorized representative **(agent)** of the patient, acknowledges that he or she personally was offered and/or received a copy of Orlando Plastic Surgery Center, LLC's Notice of Priacy Practices on the date indicated below.

Print name: _____

Signature: _____ Date: _____

_____

Information about the Agent (attach appropriate documentation)

Agent: _____

Title _____

Our receptionist will be happy to provide you with a complete copy of our Notice of Privacy Practices.

A copy of our Notice of Privacy Practices is available on our web site, www.popeplasticsurgery.com, for you to review any time.

Submit