Sergio M. Zamora, PLC
M.D., F.A.C.S.
Aesthetic & Reconstructive Plastic Surgery
Diplomate American Board of Plastic Surgery
1890 LPGA Blvd. Suite 150 • Daytona Beach, FL 32117 • Ph: 386-274-5557 • Fax: 386-274-5527

Thank you for choosing me as your physician. We are committed to your health and well-being. The following practice policy should ensure that we have a relationship of mutual respect and understanding regarding services rendered and payment of services. We ask all patients to read and sign our policy at the first appointment so that together we minimize billing problems. Also, please complete the accompanying information and insurance form prior to your first appointment. Thank you for understanding and complying with our financial policy. Please let us know if you have any questions or concerns.

- If you have an insurance plan with which we participate, and the services for which you are here are to be covered expenses, we will gladly file your insurance*claim for you. You will be billed for any amount that your insurance company leaves to your responsibility. If you have an HMO, you MUST obtain a referral authorization from your primary care physician prior to your visit.
- If our practice does not participate with your insurance company, or if there is doubt and we cannot confirm prior to your visit, you will be asked to file your Own claim and payment will be due at the time of service.
- We do not file out of state insurance. If your insurance policy is with a company outside of Florida you are expected to pay at the time of service and file your own insurance.

Please be aware that some and perhaps all of the services provided may be non-covered services, and may not be considered reasonable/necessary by"the Medicare program or other medical insurance {even though your physician may feel that such a service is reasonable and necessary).

In the event that you are unable to fulfill your financial obligation with this office in a timely manner, it is your responsibility to contact our office and speak with our billing specialist in order to resolve your situation. Failure to call and arrange payment in a responsible manner will result in your bill being forwarded to our credit bureau. Collections fees incurred as a result of a delinquent account will be your responsibility.

Minor patients: Adults accompanying a minor are responsible for payment of said minor's charges. Unaccompanied minors seeking services will only be provided treatment in emergency situations,.

For your convenience, our office accepts cash, checks, and Visa/Mastercard and American Express.

I have read the financial policy. I understand I am ultimately responsible for fees for services and agree to this policy.

_____ _____

Signature of patient or responsible party Date

Member
AMERICAN SOCIETY OF
PLASTIC SURGEONS

MEMBER OF THE AMERICAN SOCIETY
FOR AESTHETIC PLASTIC SURGERY

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for **Sergio M. Zamora. M.D., PLC** to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (**Sergio M. Zamora, M.D., PLC's** Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Sergio M. Zamora, M.D., PLC** reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to *Desiree Vincent -Privacy Officer at 1890 LPGA Blvd., Suite 150, Daytona Beach, FL 32117.*

With this consent, **Sergio M. Zamora, M.D., PLC** may call my home or other alternative location and leave a message on voice mail or in persbn in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.
With this consent, **Sergio M. Zamora, M.D., PLC** may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

I have the right to request that **Sergio M. Zamora, M.D., PLC** restrict how it uses or discloses my PHI to carry out TPO. This request must be made in writing to the Privacy Officer. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.
By signing this form, I am consenting to **Sergio M. Zamora, M.D., PLC's** use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **Sergio M. Zamora, M.D., PLC** may decline to provide treatment to me.

_____ _____
Signature of Patient or Legal Guardian Print Name of Patient or Legal Guardian

_____ _____
Witness Date

Member
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MEMBER OF THE AMERICAN SOCIETY FOR AESTHETIC PLASTIC SURGERY

SERGIO M. ZAMORA, M.D., F.A.C.S., PLC

Aesthetic & Reconstructive Plastic Surgery
Diplomate American Board of Plastic Surgery

PATIENT

Name _____
First Middle Last

Permanent Address: _____
Street City State Zip

Home Phone: ( ) _____ Patient's Social Sec. #: _____

Cell Phone: ( ) _____ Email: _____

AGE	DATE OF BIRTH	SEX	MARITAL STATUS	FAMILY PHYSICIAN	REFERRING PHYSICIAN
				PH #	PH #

PHARMACY INFORMATION: _____ Phone #: _____

In case of emergency, contact: _____ Phone #: _____

Name of nearest relative not living with you: _____ Phone #: _____

Address (street) _____ City: _____ State: _____

Zip Code _____ Referred By: _____

PATIENT'S EMPLOYER

_____
Name

_____
Street City State Zip

Phone: _____

SPOUSE NAME

_____
First Middle Last

SPOUSE'S EMPLOYER

_____

_____
Street City State Zip

Phone: _____ Spouse's Social Security #: _____

* Authorize Release Of My Medical Records To My Physician And/Or Referring Physician, If Applicable. I understand that I am financially responsible for any charges incurred.

Signed: X _____ Date: _____

* I Authorize Sergio M. Zamora, M.D., F.A.C.S., PLC To Take Photographs In Conjunction With My Medical Condition And Treatment To Be Maintained In My File.

Signed: X _____ Date: _____

This office is regulated pursuant to the rules of the Board of Medicine as set forth in Rule Chapter 64B8, F.A.C.

SERGIO M. ZAMORA, M.D., F.A.C.S., PLC

INSURANCE INFORMATION

Date _____

Patient's Name _____

Patient's Social Security # (if Patient is Minor, Parent's #) _____

PRIMARY INSURANCE INFORMATION:

Name Of Insurance Company #1: _____

Insurance Address _____

Insurance Phone # _____

Policy # _____ Group # _____

Insured's Name _____ Insured's Date of Birth _____

SECONDARY INSURANCE INFORMATION:

Name Of Insurance Company #2: _____

Insurance Address _____

Insurance Phone # _____

Policy # _____ Group # _____

Insured's Name _____ Insured's Date of Birth _____

GUARANTOR INFORMATION: if different from Insured.

Name _____

Address _____

Phone _____

Social Security # _____ Date of Birth _____

***** PLEASE HAVE YOUR INSURANCE CARDS AND DRIVERS LICENSE/I.D. AVAILABLE *****

I Hereby Authorize Release Of Medical Information Or Records To Process My Insurance Claim. I Authorize Payment Directly To The Physician For Benefits Due For This Service.

Signed: _____ Date: _____

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Daytona Beach, FL 32117

MEDICAL HISTORY SHEET

Please Answer ALL Questions & Please Print

Patient's Name _____ Date: _____

REASON FOR TODAY'S VISIT _____

_____

PLEASE LIST ANY MEDICAL PROBLEMS THAT YOU NOW OR HAVE HAD IN THE PAST

	PROBLEM	**WHEN PROBLEM BEGAN**
EXAMPLE:	***HIGH BLOOD PRESSURE***	***JULY 1989***
1.		
2.		
3.		
4.		
5.		

IF YOU HAVE HAD SURGERY, PLEASE LIST YEAR AND TYPE OF SURGERY

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
7. _____ 8. _____

WOMEN: ARE YOU PREGNANT? ____YES ___NO

FAMILY HISTORY: *If living, give present health information. If deceased, give age and cause of death.*

Father: _____ **Mother:** _____

Brothers & Sisters _____

LIST ALL CURRENT OR PRESENT MEDICATIONS

NAME	**DOSE**	**HOW OFTEN TAKEN**	**NAME**	**DOSE**	**HOW OFTEN TAKEN**

LIST ANY DRUGS YOU ARE ALLERGIC TO OR HAVE HAD ANY PROBLEMS WITH ALSO LIST SYMPTOMS

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Please list your DAILY CONSUMPTION & LENGTH OF USE of each:

HAVE YOU EVER SMOKED: ___YES ___NO

If "Yes", How Many Packs Daily? _____ How Long?_____ Do you still smoke ___Yes ___No (Date that you quit _____/_____/_____)

DO YOU CONSUME ALCOHOL: ___YES ___NO

If "Yes", Indicate the Frequency: ___Daily ___Occasionally for _____ Years

ARE YOU PRESENTLY ON ANY SPECIAL DIET?

If "Yes", Please explain: _____

_____

PLEASE SEE OTHER SIDE

REVIEW OF SYSTEMS

PLEASE indicate by checking "YES" or "NO" if you presently have or have had a history of any of the following:

WEIGHT:_____ **HEIGHT:**_____

HEAD:

Headaches	YES	NO
Seizures	YES	NO
Dizziness	YES	NO
Fainting Spells	YES	NO
Injury	YES	NO

EYES:

Double Vision	YES	NO
Blind Spots	YES	NO
Dry Eye	YES	NO
Do you wear eyeglasses	YES	NO

Type of correction_____

_____

EARS:

Ringing	YES	NO
Hard of Hearing	YES	NO
Hearing Aid	YES	NO

NOSE:

Bleeding	YES	NO
Obstruction	YES	NO
Discharge	YES	NO

MOUTH:

Fever Blisters	YES	NO
Bleeding Gums	YES	NO
Caps	YES	NO
Crowns	YES	NO
Dentures	YES	NO

THROAT:

Hoarseness	YES	NO
Soreness	YES	NO
Thyroid	YES	NO
Swallowing	YES	NO

LYMPH NODES:

Local or General Glandular Enlargement YES NO

RESPIRATORY:

TB	YES	NO
Short of Breath	YES	NO
Cough	YES	NO
Wheezing	YES	NO
Asthma	YES	NO

CARDIOVASCULAR:

Pacemaker	YES	NO
Hypertension *(High Blood Pressure)*	YES	NO
Rheumatic Fever	YES	NO
Edema *(swelling arms/legs)*	YES	NO
Heart Murmur	YES	NO
Pericardial Pain *(chest pain)*	YES	NO
Hypotension *(Low Blood Pressure)*	YES	NO
Phlebitis *(Inflammation of Veins)*	YES	NO
Heart Disease	YES	NO

GASTROINTESTINAL:

Gallbladder	YES	NO
Nausea	YES	NO
Diarrhea	YES	NO
Blood in Stool	YES	NO
Ulcer	YES	NO
Vomiting	YES	NO
Constipation	YES	NO

GENITOURINARY:

Urinary Tract	YES	NO
Venereal Disease	YES	NO
Kidney Disease	YES	NO

IF YOU HAVE ANSWERED "YES" TO ANY OF THE ABOVE, PLEASE EXPLAIN:_____

_____

_____

_____

_____

_____

_____

Are you currently being treated for any Emotional or Psychological Problems? YES NO

Have you been treated for any Emotional or Psychological Problems in the past? YES NO

If "Yes", please explain_____

_____

Have you ever had any Bleeding Problems? YES NO

Have you ever had any Bleeding Problems with a Surgical or Dental Procedure? YES NO

Have you ever had any Blood Transfusion or Blood Products? YES NO

If "Yes", please explain_____

_____

_____

Have you ever had General Anesthesia? YES NO If "Yes", Did you have a reaction to the Anesthesia?_____

_____

Have you ever been Diagnosed with an Infectious Disease such as HIV, Hepatitis, Syphilis, Tuberculosis? YES NO

If "Yes", please explain: _____

_____

THROMBOSIS RISK FACTOR ASSESSMENT

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Choose All That Apply

Each Risk Factor Represents 1 Point

- ❑ Age 41-60 years
- ❑ Minor surgery planned
- ❑ History of prior major surgery (< 1 month)
- ❑ Varicose veins
- ❑ History of inflammatory bowel disease
- ❑ Swollen legs (current)
- ❑ Obesity (BMI >25)
- ❑ Acute myocardial infarction
- ❑ Congestive heart failure (< 1 month)
- ❑ Sepsis (< 1 month)
- ❑ Serious lung disease including pneumonia (< 1 month)
- ❑ Abnormal pulmonary function (COPD)
- ❑ Medical patient currently at bed rest
- ❑ Other risk factors_____

Each Risk Factor Represents 3 Points

- ❑ Age over 75 years
- ❑ Major surgery lasting 2-3 hours
- ❑ History of DVT/PE
- ❑ Family history of thrombosis*
- ❑ Positive Factor V Leiden
- ❑ Positive Prothrombin 20210A
- ❑ Elevated serum homocysteine
- ❑ Positive Lupus anticoagulant
- ❑ Elevated anticardiolipin antibodies
- ❑ Heparin-induced thrombocytopenia (HIT)
- ❑ Other congenital or aquired thrombophilia
  If yes:

Type_____

**most frequently missed risk factor*

Each Risk Factor Represents 2 Points

- ❑ Age 60-74 years
- ❑ Arthroscopic surgery
- ❑ Malignancy (present or previous)
- ❑ Major surgery (> 45 minutes)
- ❑ Laparoscopic surgery (> 45 minutes)
- ❑ Patient confined to bed (72hours)
- ❑ Immobilizing plaster cast (< 1 month)
- ❑ Central venous access

Each Risk Factor Represents 5 Points

- ❑ Elective major lower extremity arthroplasty
- ❑ Hip, pelvis or leg fracture (< 1 month)
- ❑ Stroke (< 1 month)
- ❑ Multiple trauma (< 1 month)
- ❑ Acute spinal cord injury (paralysis)(< 1 month)

For Women Only (Each Represents 1 Point)

- ❑ Oral contraceptives or hormone replacement therapy
- ❑ Pregnancy or postpartum (<1 month)
- ❑ History of unexplained stillborn infant, recurrent spontaneous abortion (≥3), premature birth with, toxemia or growth-restricted infant

Total Risk Factor Score ☐

2005 Caprini Risk Assessment Model Reprinted with permission from Joseph A. Caprini, MD

Patient's Name:_____

Age: _____ Sex: _____ Wgt:_____lbs