DIAZ PLASTIC SURGERY
breast | body | face | medspa

Michael Diaz, MD
1513 S. Harbor City Blvd.
Melbourne, FL, 32901
P: 321-951-2639
F: 321-914-0938

NEW PATIENT REGISTRATION

Name: _____ **SSN:** _____

DOB: _____ **Age:** _____ **Sex:** _____

Address: _____

City: _____ **ST:** _____ **Zip:** _____

Cell: _____ **Home:** _____ **Work:** _____

***Email:** _____

***Providing us with your email will allow us to send you updates on special pricing and promotions.**

Opt in: ☐ **Opt out:** ☐

Insurance Carrier: _____ **Member ID#:** _____

Marital Status: _____ **Spouse Name:**
_____

Employer: _____ **Occupation:** _____

Emergency Contact: _____ **Contact Phone:** _____

Relationship: _____

Primary Care Physician: _____ **Phone:** _____

Referring Physician: _____ **Phone:** _____

_____ _____
Patient Signature **Date**

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PHOTOGRAPHIC CONSENT

I consent to the taking of photographs by Dr. Diaz or his designee of me or parts of my body in connection with the plastic surgery procedure(s) to be performed by Dr. Diaz. I provide this authorization as a voluntary contribution in the interests of public education. Neither I, nor any member of my family, will be identified by name in any publication. I understand that in some circumstances the photographs may portray features that will make my identity recognizable. I understand that such photographs are for the limited purpose of including them in any print, visual or electronic media, specifically including, but not limited to, medical journals, textbooks, advertising, and websites for the purpose of informing the medical profession or the general public about plastic surgery procedures and methods. I release and discharge Dr. Diaz and all parties acting under their license and authority, from all rights that I may refuse to authorize the release of any health information and that my refusal to consent to the release of health information will prevent the disclosure of such information, but will not affect the health care services I presently receive, or will receive, from Dr. Diaz. I understand that I have the right to inspect and copy the information that I have authorized to be disclosed. I further understand that I have the right to revoke this authorization in writing at any time, but if I do so it will not have any effect on any actions taken prior to my revocation. I understand that the information disclosed, or some portion thereof, may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 (HIPPA).

_____ _____

Patient or Guardian Signature **Date**

_____ _____

Witness **Date**

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Patient Health Questionnaire

Patient Name: _____

General:	**YES**	**NO**
Skin Cancer	☐	☐
Skin Diseases	☐	☐
Bleeding Disorder	☐	☐
Blood Clots	☐	☐
Have you ever been on "Accutane"?	☐	☐
Have you ever had cold sores?	☐	☐

Have you ever considered cosmetic body surgery, such as (please circle):

- ☐ Breast Augmentation
- ☐ Implant Exchange
- ☐ Breast Lift
- ☐ Breast Reduction
- ☐ Tummy Tuck
- ☐ Liposuction
- ☐ Arm Lift
- ☐ Thigh Lift
- ☐ Lower Body Lift
- ☐ Upper Body Lift
- ☐ Revisional Surgery
- ☐ Facial Surgery
- ☐ Neck Lift
- ☐ Eyelids

Would you like to discuss this with Dr. Diaz? ☐YES ☐NO

Please list all the operations you have had (including prior plastic surgery):

_____

Please list all medications you take regularly (include prescription, over the counter, and vitamin supplements):

_____

Do you smoke (cigarettes, E-cig, vapors, pipes)? ☐YES ☐NO How much? _____

Do you drink (beer, wine, etc.)? ☐YES ☐NO How much? _____

Do you use recreational drugs (Marijuana, Cocaine, etc.)? ☐YES ☐NO How much? _____

Do you have any allergies? ☐YES ☐NO Please list (drug and food allergies):

_____

Please describe any other any problem which may not have been covered above and which you would like the doctor to know about (hypertension, C-Diff, MRSA, HIV, Hepatitis, Etc.):

_____

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Patient Name: _____

Head and Neck:	**YES**	**NO**
Snoring	☐	☐
Sinusitis	☐	☐
Facial Pain	☐	☐
Local skin lesions that have changed recently	☐	☐
Lumps or swelling of the head or neck	☐	☐
EYES:		
Dry Eyes	☐	☐
Itchy/Watery Eyes	☐	☐
RESPIRATORY SYSTEM:		
Chronic Cough	☐	☐
Wheezing, asthma	☐	☐
History of lung cancer	☐	☐
Allergies	☐	☐
NEUROLOGIC:		
Seizures	☐	☐
Strokes	☐	☐
Head Injury	☐	☐
CARDIOVASCULAR SYSTEM:		
Heart Murmur	☐	☐
Chest Pain	☐	☐
Swelling of the ankles	☐	☐
Shortness of breath on exertion	☐	☐
Heart Surgery or Angioplasty	☐	☐
High/Low Blood Pressure	☐	☐
ENDOCRINE:		
Diabetes	☐	☐
Over or underactive thyroid	☐	☐
UROGENTIAL:		
Frequent Urination	☐	☐
Prostate problems	☐	☐
Kidney Disease	☐	☐
GASTROINTESTINAL:		
Heartburn or ulcers	☐	☐
Jaundice, liver disease, hepatitis	☐	☐
HISTORY (family or personal) OF:		
Breast lumps or masses	☐	☐
Nipple Discharge	☐	☐
Breast Cancer	☐	☐
HISTORY OF INFECTIOUS DISEASES:		
C-Diff	☐	☐
MRSA	☐	☐
TB	☐	☐

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Name_____ Age_____ Gender_____

Thank you for considering Dr. Michael Diaz and the Diaz Plastic Surgery for your procedure. Your feedback is appreciated. Please take the time to answer the questions below. The information you provide is extremely important to us.

What procedure are you considering?:

How did you hear about Dr. Diaz? ***(Please mark all that apply)***

- ☐ Friend (who)_____
- ☐ Physician Referral (who)_____
- ☐ Previous Patient (who)_____
- ☐ Business Organization (which)_____
- ☐ Internet
  - diazplasticsurgery.com☐
  - Google☐
  - Smart Plastic Surgery☐
  - Vitals☐
  - Real Self☐
  - YouTube☐
  - Health Grades☐
  - YellowPages.com☐
  - Facebook☐
  - Constant Contact Email Promotion (which)_____
  - Other (which)_____
- ☐ Yellow Pages
- ☐ Radio

  98.5 The Beach☐ Lite Rock 99.3☐ KISS 95.1 ☐ 102.7 Hit Kicker☐
- ☐ Television

  Bright House☐ NBC☐ ABC☐ CBS☐ FOX☐
- ☐ Florida Today
- ☐ Health & Medicine
- ☐ Moms
- ☐ Style
- ☐ Space Coast Living
- ☐ Mailer (time of year)_____
- ☐ Symposium(which)
  - Breast & Body☐
  - Weight Loss☐
  - Mommy Makeover☐
  - Skin Care Solutions☐
  - Other (which)_____
- ☐ Kiwi Tennis Club
- ☐ Event (which)_____
- ☐ Other_____

Thank you for taking the time to fill in this information.