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

O Tummy Tuck
O Liposuction
O Arm Lift
O Thigh Lift

O Lower Body Lift
O Upper Body Lift
O Revisional Surgery
O Facial Surgery

O Neck Lift
O 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)***

0 Friend (who)_____
0 Physician Referral (who)_____
0 Previous Patient (who)_____
0 Business Organization (which)_____
0 Internet
- diazplasticsurgery.com____
- Google____
- Smart Plastic Surgery____
- Vitals____
- Real Self____
- YouTube____
- Health Grades____
- YellowPages.com____
- Facebook____
- Constant Contact Email Promotion (which)_____
- Other (which)_____

0 Yellow Pages
0 Radio

98.5 The Beach____ Lite Rock 99.3_____ KISS 95.1 _____ 102.7 Hit Kicker____

0 Television

Bright House____ NBC____ ABC____ CBS____FOX____

0 Florida Today
0 Health & Medicine
0 Moms
0 Style
0 Space Coast Living
0 Mailer (time of year)_____
0 Symposium(which)
- Breast & Body_____
- Weight Loss_____
- Mommy Makeover_____
- Skin Care Solutions_____
- Other (which)_____

0 Kiwi Tennis Club
0 Event (which)_____
0 Other_____

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