

D. Scott Rotatori, M.D., P.A.

PATIENT INFORMATION

Patient Name _____
LAST FIRST MIDDLE

Today's Date _____ Account # _____

Date of Birth _____ Age _____ Sex _____ Race _____ SS# _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone () _____ Cell Phone () _____

Employer _____ Work Phone () _____

Occupation: _____ E-mail address* _____

PARENT OR SPOUSE INFORMATION

Name _____ Relationship _____ Date of Birth _____

Mailing Address (if different from Patient) _____

Home Phone () _____ Work Phone () _____

Employer _____ Address _____

* Would you like to receive specials and newsletters through email? Yes No

Referred by _____ Address _____ Phone _____

May we write a letter to your referral source, thanking them for referring you? Yes No

Reason for Visit _____

Have you been treated elsewhere for this problem? _____ If so, by whom? _____

Name/Address of Primary Care Physician _____

Would you like your records from each visit here, released to (if yes, please check and sign below):

Your Primary Care Doctor? Yes No _____

Signature Date

Your referring Doctor? Yes No _____

Signature Date

IF ACCIDENT RELATED, PLEASE COMPLETE THE FOLLOWING

Date of Accident _____ Time _____ Describe how accident happened: _____

Any legal proceedings involved regarding this visit Yes No

NAME OF INSURANCE CARRIER: _____

How do you plan to pay for this visit? Cash Check Insurance Credit Card

EMERGENCY CONTACT PERSON

Emergency contact person (or friend) other than a relative, who does not reside with you:

Name _____ Address _____ Phone _____

MEDICAL HISTORY

Height _____ Weight _____ Exercise? _____ Diet? _____

Do you use Tobacco? _____ Alcohol? _____ Drugs? _____
If yes, how much? _____

Have you had a recent weight loss or gain? _____ If yes, please explain.

Please list any allergies. _____

Do you have a history of Sleep Apnea or Snoring? _____ yes _____ no

Surgical History: _____

Other Hospitalizations: _____

Have you been treated for any medical problems? _____, If yes, please explain: _____

Have you ever seen a psychologist or psychiatrist? _____

Are you currently under treatment by a psychologist or psychiatrist? _____

_____ Heart Problems: _____

_____ Lung Problems: _____

_____ Kidney Problems: _____

_____ Coughing up or Vomiting Blood: _____

_____ Blood in urine or stool: _____

_____ Seizures or loss of consciousness: _____

_____ High Blood Pressure: _____

_____ Diabetes: _____

_____ Cancer: _____

_____ Hepatitis or yellow jaundice: _____

_____ Thyroid Disease: _____

_____ Other: _____

List any other medications you are currently taking, including over-the-counter drugs and herbal supplements: _____

Personal or family history of anesthesia or bleeding problems? If so, please explain:

D. Scott Rotatori, M.D., P.A.

Notice of Privacy Practices

- This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.
- At D. Scott Rotatori, M.D., P.A., we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.
- The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.
- We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.
- We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.
- We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.
- We may use your information to contact you. For example, we may send newsletters or other information or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.
- In an emergency, we may disclose your health information to a family member or another person responsible for your care.
- We may release some or all of your health information when required by law.
- If this practice is sold, your information will become the property of the new owner.
- Except as described above, this practice will not use or disclose your health information without your prior written authorization.
- You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.
- You have the right to know of any uses or disclosures we make with your health information beyond that above normal uses.
- As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.
- You have the right to transfer copies of your health information to another practice. We will mail your files for you.
- You have the right to see and receive a copy of your health information. With a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.
- You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove or alter earlier documents, but will add new information.
- You have the right to receive a copy of this notice.
- If we change any of the details of this notice, we will notify you of the change at your next appointment after the effective date of the change.
- You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, SW, Room 509-F, Washington, DC 20201. You will not be retaliated against for filing a complaint.
- However, before filing a complaint, or for more information, or assistance regarding your health information privacy, please contact our office at (407) 628-5476.

This notice goes into effect as of April 14, 2003

Acknowledgement

I have received a copy of the D. Scott Rotatori, M.D., P.A.; Notice of Privacy Practices.

Signed _____ Print Name _____ Date _____

If signing as a parent or guardian, please note the name of the patient _____

D. Scott Rotatori, M.D., P.A.
Contemporary Cosmetic Plastic Surgery
Cosmetic, Plastic and Reconstructive Surgery
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Member – The American Society of Plastic Surgery

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**Patient Request for Allowances, Limitations
And/or Restrictions of Protected Health Information**

Please note: The practice is not required to agree to your request. Please refer to Our Notice of Privacy Practices for additional information about such requests.

Patient to complete the following:

Name: _____ Date of Birth: _____

Address: _____

Type of Protected Health Information to be restricted or limited:

To whom may we release information: (ex: __ spouse, __ significant other, __ caretaker, __ etc.)

****Note**** Often spouses, significant others, caretakers, friends, may call on behalf of the patient especially after surgery to speak with the nurse or other staff members, or to confirm appointment dates and times. Without written consent of the patient we cannot give out any information to anyone other than the patient in compliance with HIPPA law.

To whom may we not release information:

Signature of Patient or Legal Guardian

Date