The Galleria Surgery Center
Henry F. Garazo, MD, FACS | Plastic Surgery Services
1140 Conrad Court | Hagerstown, MD 21740
P: 301-791-1800 | F: 301-791-9253
www.plasticsurgeryservices.net

Welcome To Our Office!

Today's Date:

□ Mr. □ Mrs. □ Ms. □ Miss □ Dr. □ Female □ Male

Name: _____ What name do you prefer to be called? _____

Home Address: _____

City: _____ State: _____ Zip: _____

Telephone: ( ) _____ May We Leave A Message? YES NO

Cell Phone: ( ) _____ May We Leave A Message? YES NO

Work Phone: ( ) _____ May We Contact You At Work? YES NO

Birth Date: ____/____/____ Age: _____

Email Address: _____ Would you like to join our email List? YES NO

Do you have a Facebook? □ Yes □ No Instagram? □ Yes □ No

Occupation: _____ SSN: _____

Marital Status: □ Single □ Married □ Widowed □ Divorced

Employer: _____

Employer's Address: _____

Who Referred You? _____ Family Physician: _____

Your physician will be notified of your visit and result(s) unless otherwise stated NO

Cardiologist (if applicable): _____

Responsible Party Or Next Of Kin: _____

Relationship To Patient: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Telephone: ( ) _____ Cell Phone: ( ) _____

Birth Date: ____/____/____ Age: _____

Occupation: _____ SSN: _____

Employer: _____

Employer's Address: _____

Work Phone: ( ) _____

How did you learn about our practice? (Please Circle)

- Internet – What Web Site? _____
- PlasticSugeryServices.Net Web Site?
- Hagerstown Magazine
- Friend – Who? _____ ● Other Patient – Who? _____ ● Phone Book:

I give permission for photographs to be taken before, during, and after my procedure or surgery for the purposes of documentation.

Sign _____

Date_____

I, the undersigned, am aware that I am financially responsible for all services rendered to me by Dr. Garazo and Plastic Surgery Services. I am aware that I am personally responsible for all co-payments, deductibles, and noncovered services as dictated by my insurance coverage.

I, the undersigned, hereby authorize Dr. Garazo and Plastic Surgery Services to apply for benefits for covered services rendered by the Practice and request that the payments from my insurance carrier are paid directly to the practice.

I certify that the information I have provided regarding my identity and insurance coverage is correct, and further authorize the release of any necessary information, including medical information for this or any related claim to my insurance carrier(s). I permit a copy of this authorization to be used in place of the original.

I, the undersigned, am aware that I will be charged a fee of $150.00 for any cosmetic appointment/cosmetic consultation I cancel without a twenty-four (24) hour notice. I am aware that I will be charged the amount of the service scheduled for any no-show appointments.

In the event of a no-show for a Medical Spa appointment, I understand that I will be charged for the entire amount of the service. In the event of a no-show to a prepaid service, I understand that I forfeit one session.

Patient Signature_____ Date_____

PLASTIC SURGERY SERVICES **MEDICAL HISTORY SHEET** HENRY F. GARAZO, MD, FACS

Name: _____ DOB: _____ Today's Date: _____ Chart #: _____
Age: _____ Height: _____ Weight: _____ lbs. _____ inches
Fitz: _____ (PSS Weight: _____ BMI: _____)

Allergies: _____

Reason for today's visit:

MEDICAL HISTORY: Please place a Y/N next to each:

__Skin Cancer (BCC/SCC/Melanoma) Location:_____
__Heart Problems (heart attack, chest pain, pacemaker, irregular heartbeat)
__Blood Thinning Medications (Aspirin, Plavix, Coumadin, Warfarin, Aggrenox, Pradaxa, Xarelto)
__High Blood Pressure
__Circulation Problems/Ankle Swelling
__Leg or Lung Clots
__Stroke, TIA, Seizure
__Asthma/Shortness of Breath/COPD/Sleep Apnea
__Anesthesia Problems/Airway Problems/PONV __muscle spasms
__Malignant Hyperthermia, __high fever,__ neuromuscular disease
__Diabetes (Oral Meds or Insulin)

__Thyroid Problems (Hyper, Hypo)
__Cancer (Type: _____ Date: _____)
__Recent cold/Infection or chronic illness _____
__Cold sores, Herpes
__HIV, Hepatitis, Blood Transfusions, Refusal of blood or blood products
__Mental Health (depression, anxiety, eating disorders, cutting, etc.) __High Cholesterol
__Other_____

LIST MEDICATIONS: (Rx and Over the counter medications)

_____
_____
_____
_____
_____
_____
_____

FAMILY HISTORY:
What family member:

Skin Cancer: _____
Melanoma: _____
Breast Cancer: _____
Anesthesia Problems: _____
(Malignant Hyperthermia, high fever,neuromuscular disease)
Bleeding Problems/Clots: _____
Other: _____

SURGICAL HISTORY: (Please put YEAR of surgery)

___Breast biopsy __ Right __ Left_Breast
___C-Section
___Hysterectomy
___Appendectomy
___Gallbladder
___Past Cosmetic Surgery: _____
___Other Surgery:_____

Smoker? Y or N Started: _____ Amount? __/week Alcohol Use? Y or N
Amount: ____/day Quit: _____ Y / N _____ History of IV drug use

OFFICE USE ONLY:

EXAM: __HEENT
__Respiratory
__Heart
__GI/GU
__Skin/Musc

IMPRESSION/PLAN:

NOTES: 1. Schedule
2. F/U prn

Reviewed by J. Shannon, RN | E. Spickler, RN. (2023)

Health Insurance Portability & Accountability Act (HIPAA)

I have been provided with a Notice of Privacy Practices, in compliance with HIPAA regulators. I have read and understand my rights under HIPAA as provided to me by Dr. Garazo and Plastic Surgery Services.

I authorize Plastic Surgery Services to contact me for the following reasons:

Permission to call me at home, office, or mobile to confirm or reschedule an appointment or to return my message(s).

Permission to leave appointment reminders or appointment cancellation notifications on an answering machine, with a family member, assistant, or household employee.

Permission text, email or call regarding appointments. These services are provided as courtesy by our practice. I understand that by giving my permission for the above services, I have in no way authorized the release of any confidential medical information.

Patient Name: _____ Signature:

_____ Date: _____

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Cosmetic medical services or procedures of interest to you (please check all that apply)

Cosmetic Surgical Procedures

- □ Breast Augmentation (Enlargement)
- □ Mastopexy (Breast Lift)
- □ Abdominoplasty (Tummy Tuck)
- □ Gynecomastia (Male Breasts)
- □ Liposuction
- □ Face Lift
- □ Blepharoplasty (Eyelids)
- □ Breast Reduction
- □ Fat Injections / Lip Enhancement
- □ Otoplasty (Protruding Ears)

Cosmetic Non-Surgical Procedures

- □ Botox/Dysport Injection For Wrinkles
- □ Injectable Fillers (Voluma, Juvederm, Volbella, Vollure)
- □ Kybella
- □ Chemical Peels
- □ PRP for hair loss
- □ Diamond Glow Facial /Microdermabrasion
- □ iS Clinical Innovative Facial
- □ Skin Care Clinic
  -Featuring iS Clinical, SkinMedica, SkinCeuticals
- □ Microneedling/PRP (collagen induction therapy)
- □ Dermaplaning

How did you hear about us?

My physician, whose full name is _____

A friend or family member (name) _____

Another person not listed above _____

My insurance company provider directory _____

A seminar where I saw the doctor. The event was _____

An article or ad in _____

Internet (which site) _____

Member
AMERICAN SOCIETY OF PLASTIC SURGEONS

The Aesthetic Society®