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 and educational purposes that may be in a photo book, on the PSS website or Social Media outlets only provided my identity is not revealed by the pictures.

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 non-covered 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 with regard to 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 $50.00 for any Dermatology appointment 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.

Patient Signature_____ Date_____

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

Name: _____ Date: _____ Chart#: _____ **ALLERGIES**: _____
Birth Date: _____ Age: _____ Height: _____ Weight: _____lbs. _____
Fitz: PSS Wt: _____lbs. _____
REASON FOR VISIT TODAY: _____
_____
_____
_____

LIST PROBLEM AREAS: (If Applicable)

1) _____;	Duration: _____	Bleed /Scab/Crust: __	Itch: __	Pain: __	↑size: __	Δ 'd color: __
2) _____;	Duration: _____	Bleed /Scab/Crust: __	Itch: __	Pain: __	↑size: __	Δ 'd color: __
3) _____;	Duration: _____	Bleed /Scab/Crust: __	Itch: __	Pain: __	↑size: __	Δ 'd color: __

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

OFFICE USE ONLY:

EXAM: __HEENT
__Respiratory
__Heart
__GI/GU
__Skin/Musc
__Neuro
__Heme/Lymph

IMPRESSION/PLAN:

NOTES: 1. Schedule
2. F/U prn

☐ Info In Mail

• Reviewed By: J, Shannon RN ● E. Spickler RN

J.

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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Person or persons to whom Plastic Surgery Services may disclose personal health information regarding treatment on your behalf. The order shall remain in the effect until revoked by me.

Name/Relation: _____ Telephone: ( ) _____

*Our office will file insurance for all reimbursable services, to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductible, co-pay, and non-covered service amounts.

*I acknowledge that I have received a copy of the Privacy Notice for Plastic Surgery Services. This refers to the HIPPA Policy which states we cannot give your information out to anyone without your consent.

*Please be advised that completing preliminary health and insurance questionnaires does not establish a physician-patient relationship with this practice. Dr. Garazo will review your health history and conduct an initial evaluation to determine whether you are a suitable candidate and whether the practice will accept you as a patient.

_____
Printed Name

_____
Signature

_____
Date

_____
Witness

I authorize the release of any medical information necessary to process my claim.

Signed:_____
_
(Patient or Responsible Party)

Date: _____

Updated: 03/2023