



Member of the  
American Society of  
Plastic Surgeons

**Issa F. Baroudi M.D., P.A.**  
3222 Tamiami Trail  
Port Charlotte, FL 33952  
Voice: (941) 627-5155  
[www.baroudimd.com](http://www.baroudimd.com)



**CIRCLE WHERE APPLICABLE. YOU MAY CIRCLE MORE THAN ONE**

**\*\*\*PRINT LEGIBLY\*\*\***

**Patient Name:** \_\_\_\_\_  
First Middle Initial Last

**I would like to be called:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Social Security Number:** \_\_\_\_\_

**Gender:** Male Female

**Marital Status:** Single Married Divorced Legally Separated Widowed

**Address:** \_\_\_\_\_  
Street Apt. #

\_\_\_\_\_  
City State Zip

**Home Phone:** ( ) \_\_\_\_\_

**Work Phone:** ( ) \_\_\_\_\_

**Cell Phone:** ( ) \_\_\_\_\_

**Email Address:** \_\_\_\_\_

**How did you hear about us?** Physician Referral \_\_\_\_\_ Previous Patient

Newspaper Yellow Pages Our Website Internet Our Facility/Electronic Sign

Friend Referral \_\_\_\_\_ Other \_\_\_\_\_

**Place of Employment:** \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_

**Relationship:** \_\_\_\_\_ **Phone:** ( ) \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



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The Mark of Distinction  
In Cosmetic Plastic Surgery®

Circle your choices

PLEASE FILL OUT COMPLETELY

Patient Name: \_\_\_\_\_

What is your current height? \_\_\_\_\_ What is your current weight? \_\_\_\_\_

Are you pregnant? (If applicable)                      Yes                      No

**Family History**

High Blood Pressure                      Breast Cancer                      Prostate Cancer                      Diabetes  
Skin Cancer                      Heart Disease                      Stroke                      Other \_\_\_\_\_

**Social History**

Do you consume alcohol?                      No                      Yes                      How often? \_\_\_\_\_  
Do you smoke?                      No                      Yes                      Number of packs per day \_\_\_\_\_  
Have you ever smoked?                      No                      Yes                      If yes, when did you quit? \_\_\_\_\_

**Medical History**

Heart Attack                      Mitral Valve Prolapse                      Pacemaker                      Stroke                      Heart Conditions  
Lung                      Asthma                      Liver                      Hepatitis                      High Blood Pressure                      Kidney                      Thyroid  
Diabetes                      Blood Clots                      Anemia                      Seizures                      Cancer                      Radiation                      Chemotherapy  
Have you ever had a serious infection?                      Yes                      No

Please explain in detail any conditions checked above or any conditions that are currently under treatment by another physician:

\_\_\_\_\_  
\_\_\_\_\_

**Medications**

What medicines are you presently taking regularly? (Including topical cortisone cream), Aspirin.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Allergies**

Are you allergic to any medications or foods? \_\_\_\_\_

**Surgical History**

List all operations you have had: \_\_\_\_\_  
\_\_\_\_\_

Have you ever had difficulties with Local Anesthesia? \_\_\_\_\_ General Anesthesia? \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



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**PATIENT CONSENT FORM**

**Patient Payment Responsibility**

I understand I am responsible for payment of services and/or procedures rendered by Issa F. Baroudi, M.D., P.A. and Promenades Surgery Center L.L.C. I understand all balances deemed my responsibility by my insurance carrier for services and/or procedures provided by Issa F. Baroudi, M.D., P.A. at Promenades Surgery Center L.L.C. will be invoiced to me and payable to the provider of service within (30) thirty days of receipt. In the event it is deemed medically necessary for me to be transferred to an area hospital, I understand I will be responsible for all services incurred with this transfer. Patient responsibilities can include all applicable co-payments, deductibles, and co-insurance amounts. In the event my insurance carrier sends payment of services directly to me, I understand I must forward this payment onto the provider of service. All procedures and/or services deemed not medically necessary or are not covered by my insurance carrier are my responsibility. I understand it is my responsibility to know the terms of my insurance contract. It is my responsibility to notify Issa F. Baroudi, M.D., P.A. and Promenades Surgery Center L.L.C. of any changes on my account which include insurance information, change of address, change of phone number or name change.

**Medicare Assignment**

I have been informed Issa F. Baroudi, M.D., P.A. and Promenades Surgery Center, L.L.C. participate and accept Medicare Assignment.

**Payment Policies and Assignment of Benefits**

A statement for unpaid balances will be sent to me on a monthly basis. It is my responsibility to ensure full payment within 30 days of receipt. I understand if my balance remains unpaid after (90) ninety days, the provider of service will post my account as a collection account. I understand all accounts having a “collection status” will be settled in a court of law. I understand I will be responsible for any and all attorney and court fees. Payments can be made by Credit Card, Check, Cash, or Money Order. If paying by check and it is returned by my bank for any reason, I understand I will receive a separate invoice for the Return Check Fee as well as the amount of the check. This amount must be paid within (7) Seven Business days by Money Order, Cash, or Credit Card. All returned checks not paid will be forwarded to the Florida District Attorneys office. I have been informed Issa F. Baroudi, M.D., P.A. and Promenades Surgery Center L.L.C. operate as separate entities. I understand I may receive a separate statement from a laboratory if testing is required and also for anesthesia if required. I hereby assign my insurance benefits to be paid directly to the provider of service.

**Release of Medical Information**

I understand Issa F. Baroudi, M.D., P.A. and Promenades Surgery Center L.L.C. are permitted to make uses and disclosures of my health information for the purposes of treatment, payment and health care operations. Protected health information is the information created and obtained in providing the services to me. Such information may include documenting my symptoms, test results, surgical procedures, diagnoses, and complications. It also includes billing documents for those services.

I hereby authorize the provider of service to disclose my health information for the sole purpose of treatment, payment and healthcare operations. This form is provided to me to comply with Federal Privacy Law (HIPPA) the Health Insurance Portability and Accountability Act of 1996. The Practice has a Notice of Privacy Practices and I understand I have the opportunity to review it.

**Consent to Taking of Photographs**

I hereby consent and agree: Photographs may be taken of me or parts of my body with the consent of Issa F. Baroudi, M.D., P.A. and under such conditions and at such times as may be approved by Issa F. Baroudi M.D., P.A. I release and discharge Issa F. Baroudi, M.D., P.A. and Promenades Surgery Center L.L.C., and all parties acting under their license and authority, from any and all claims or actions that I have or may have relating to, my pictures being taken.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_