



Mark D. McDonough, M.D., P.A.

Plastic and Reconstructive Surgery

615 Princeton Street, Suite #540 Orlando, Florida 32803

(407) 896-4440 (407) 896-4410 Fax

Email: mcd@drmcDonough.com • Website: www.drmcDonough.com

DR./MRS./MS./MR: _____ DATE: _____

BY WHAT NAME WOULD YOU PREFER TO BE ADDRESSED?: _____

CELL PHONE #: _____ HOME PHONE #: _____ WORK PHONE #: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

SECONDARY ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

AGE: _____ DATE OF BIRTH: _____ S.S. #: _____

SEX M _____ F _____ MARITAL STATUS: (CIRCLE ONE) SINGLE MARRIED DIVORCED SEPARATED WIDOW

SPOUSE (IF MARRIED) NAME: _____ PHONE #: _____ DOB: _____

PATIENT EMPLOYER: _____ OCCUPATION: _____

REFERRING DR: _____ PHONE #: _____ PRIMARY DR: _____

WHO MAY WE THANK FOR REFERRING YOU TO OUR PRACTICE?: _____

REASON FOR VISIT: _____

=====

PRIMARY INSURANCE CO: _____ PHONE #: _____

POLICY NUMBER: _____ GROUP #: _____

NAME OF POLICY HOLDER: _____ EMPLOYER: _____

POLICY HOLDER S.S. #: _____ DOB: _____ RELATIONSHIP: _____

SECONDARY INSURANCE CO: _____ PHONE #: _____

POLICY NUMBER: _____ GROUP #: _____

NAME OF POLICY HOLDER: _____ EMPLOYER: _____

POLICY HOLDER S.S. #: _____ DOB: _____ RELATIONSHIP: _____

RELEASE OF INFORMATION:
I CERTIFY THAT THE INFORMATION I HAVE REPORTED WITH REGARD TO MY INSURANCE CARRIER IS CORRECT. I AUTHORIZE THE RELEASE OF ANY NECESSARY INFORMATION, INCLUDING MEDICAL INFORMATION TO MY INSURANCE CARRIER, ATTORNEY, PHYSICIAN, HOSPITAL, MEDICARE OR OTHER MEDICAL FACILITY. I UNDERSTAND THAT I HAVE THE RIGHT TO SEE THE PRIVACY PRACTICES FOR MARK D. MCDONOUGH, M.D., P.A., WHICH ARE AVAILABLE UPON REQUEST.

PATIENT/GUARDIAN SIGNATURE

DATE



Mark D. McDonough, M.D., P.A.

Plastic and Reconstructive Surgery

615 Princeton Street, Suite #540 Orlando, Florida 32803

(407) 896-4440 (407) 896-4410 Fax

Email: mcd@drmcDonough.com • Website: www.drmcDonough.com

Please list all Personal Illnesses:

Please list all past surgeries/injuries with dates:

Allergies: Medications: _____ Foods: _____ Cosmetics: _____

Please list any Allergies: _____

Current Medications (Please include over the counter medications):

Vitamin Use: _____ Currently using/dosage: _____

Herbal Use: _____ Currently using/dosage: _____

Number of Children: _____ Number of Pregnancies: _____

Are you a smoker? _____ How much? _____/day How long? _____

Date Quit: _____

Alcohol: How much? _____/day Caffeine (coffee, tea, colas) _____/day

Have you had previous Cosmetic or Facial/Laser Surgery? _____

Type of Procedure/Date/Doctor: _____

Have you ever taken/used the following medications:

Accutane: _____ Glycolic acids: _____ Retin A: _____

What is your current skin care program? _____

Family History: (Please check if applicable)

Diabetes _____ Heart Disease: _____ Stroke: _____ TB: _____

High Blood Pressure: _____ Kidney Disease: _____ Anemia: _____ Arthritis: _____

Mental Illness: _____ Cancer: _____ Type of Cancer: _____

Please list any significant Family Illnesses:

Mother: Living: _____ Deceased: _____ Age: _____ Cause of Death: _____

Father: Living: _____ Deceased: _____ Age: _____ Cause of Death: _____



Mark D. McDonough, M.D., P.A.

Plastic and Reconstructive Surgery

615 Princeton Street, Suite #540 Orlando, Florida 32803

(407) 896-4440 (407) 896-4410 Fax

Email: mcd@drmcDonough.com • Website: www.drmcDonough.com

PLEASE CHECK EACH ITEM "YES" OR "NO" AS THEY RELATE TO YOUR HEALTH

| <u>CONSTITUTIONAL</u> | Yes | No | <u>RESPIRATORY</u> | Yes | No | <u>MUSCULOSKELETAL</u> | Yes | No |
|--------------------------|--------------------------|--------------------------|------------------------------|--------------------------|--------------------------|---------------------------------------|--------------------------|--------------------------|
| Weight Loss | <input type="checkbox"/> | <input type="checkbox"/> | Cough | <input type="checkbox"/> | <input type="checkbox"/> | Joint Pain/Swelling | <input type="checkbox"/> | <input type="checkbox"/> |
| Fatigue | <input type="checkbox"/> | <input type="checkbox"/> | Coughing Blood | <input type="checkbox"/> | <input type="checkbox"/> | Stiffness | <input type="checkbox"/> | <input type="checkbox"/> |
| Fever | <input type="checkbox"/> | <input type="checkbox"/> | Chills | <input type="checkbox"/> | <input type="checkbox"/> | Muscle Pain | <input type="checkbox"/> | <input type="checkbox"/> |
| <u>EYES</u> | | | <u>GASTROINTESTINAL</u> | | | <u>SKIN</u> | | |
| Glasses/Contacts | <input type="checkbox"/> | <input type="checkbox"/> | Heartburn | <input type="checkbox"/> | <input type="checkbox"/> | Rash/Sores | <input type="checkbox"/> | <input type="checkbox"/> |
| Pain | <input type="checkbox"/> | <input type="checkbox"/> | Nausea/Vomiting | <input type="checkbox"/> | <input type="checkbox"/> | Lesions | <input type="checkbox"/> | <input type="checkbox"/> |
| Double Vision | <input type="checkbox"/> | <input type="checkbox"/> | Constipation | <input type="checkbox"/> | <input type="checkbox"/> | Itching/Burning | <input type="checkbox"/> | <input type="checkbox"/> |
| Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> | Change in BMs | <input type="checkbox"/> | <input type="checkbox"/> | <u>NEUROLOGICAL</u> | | |
| Cataracts | <input type="checkbox"/> | <input type="checkbox"/> | Diarrhea | <input type="checkbox"/> | <input type="checkbox"/> | Seizures | <input type="checkbox"/> | <input type="checkbox"/> |
| <u>EAR, NOSE, THROAT</u> | | | Difficulty Swallowing | <input type="checkbox"/> | <input type="checkbox"/> | Weakness/Paralysis | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty Hearing | <input type="checkbox"/> | <input type="checkbox"/> | Jaundice | <input type="checkbox"/> | <input type="checkbox"/> | Numbness | <input type="checkbox"/> | <input type="checkbox"/> |
| Ringing in Ears | <input type="checkbox"/> | <input type="checkbox"/> | Abdomen Pain | <input type="checkbox"/> | <input type="checkbox"/> | Tremors | <input type="checkbox"/> | <input type="checkbox"/> |
| Vertigo | <input type="checkbox"/> | <input type="checkbox"/> | Black BM | <input type="checkbox"/> | <input type="checkbox"/> | Memory Loss | <input type="checkbox"/> | <input type="checkbox"/> |
| Sinus Trouble | <input type="checkbox"/> | <input type="checkbox"/> | <u>GENITOURINARY</u> | | | <u>ENDOCRINE</u> | | |
| Nasal Stuffiness | <input type="checkbox"/> | <input type="checkbox"/> | Pain Urinating | <input type="checkbox"/> | <input type="checkbox"/> | Loss of Hair | <input type="checkbox"/> | <input type="checkbox"/> |
| Frequent Sore Throat | <input type="checkbox"/> | <input type="checkbox"/> | Burning | <input type="checkbox"/> | <input type="checkbox"/> | Heat/Cold Intolerance | <input type="checkbox"/> | <input type="checkbox"/> |
| Hoarseness | <input type="checkbox"/> | <input type="checkbox"/> | Frequency | <input type="checkbox"/> | <input type="checkbox"/> | Change in Nails | <input type="checkbox"/> | <input type="checkbox"/> |
| <u>CARDIOVASCULAR</u> | | | Blood in Urine | <input type="checkbox"/> | <input type="checkbox"/> | <u>HEMATOLOGIC/LYMPH</u> | | |
| Murmur | <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Discharge | <input type="checkbox"/> | <input type="checkbox"/> | Easy Bruising | <input type="checkbox"/> | <input type="checkbox"/> |
| Chest Pain | <input type="checkbox"/> | <input type="checkbox"/> | Difficulty Urinating | <input type="checkbox"/> | <input type="checkbox"/> | Gums Bleed Easily | <input type="checkbox"/> | <input type="checkbox"/> |
| Palpitations | <input type="checkbox"/> | <input type="checkbox"/> | History Kidney Stone | <input type="checkbox"/> | <input type="checkbox"/> | Enlarged Glands | <input type="checkbox"/> | <input type="checkbox"/> |
| Dizziness | <input type="checkbox"/> | <input type="checkbox"/> | History Sexually - | | | Prolonged Bleeding | <input type="checkbox"/> | <input type="checkbox"/> |
| Fainting Spells | <input type="checkbox"/> | <input type="checkbox"/> | Transmitted Disease | <input type="checkbox"/> | <input type="checkbox"/> | <u>ALLERGIC/IMMUNOLOGIC</u> | | |
| Short of Breath | <input type="checkbox"/> | <input type="checkbox"/> | | | | Hay Fever/Asthma | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty Lying Flat | <input type="checkbox"/> | <input type="checkbox"/> | <u>FEMALE ONLY:</u> | | | Hives/Eczema | <input type="checkbox"/> | <input type="checkbox"/> |
| Swelling Ankles/Other | <input type="checkbox"/> | <input type="checkbox"/> | Are Periods Regular | <input type="checkbox"/> | <input type="checkbox"/> | <u>PSYCHIATRIC</u> | | |
| | | | Age of Onset Periods: _____ | | | Anxiety/Depression | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Age of Onset Menopause _____ | | | Mood Swings or Difficulty Sleeping | <input type="checkbox"/> | <input type="checkbox"/> |



Mark D. McDonough, M.D., P.A.

Plastic and Reconstructive Surgery

615 Princeton Street, Suite #540 Orlando, Florida 32803

(407) 896-4440 (407) 896-4410 Fax

Email: mcd@drmcdonough.com • Website: www.drmcdonough.com

Financial Policy

Thank you for choosing us as your health care provider. We are committed to providing you with safe and confidential care. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. The following is a statement of our Financial Policy, which we ask that you read and sign prior to any treatment.

FOR ELECTIVE PROCEDURES NOT COVERED BY INSURANCE, FULL PAYMENT IS DUE AT TIME OF SERVICE. WE ACCEPT CASH, CHECKS AND MOST CREDIT CARDS.

For those procedures and services that are covered by insurance, we will be happy to bill your carrier for you after the service has been rendered. Please be aware that some, and perhaps all, of the services provided may be non-covered or not considered reasonable and necessary under some insurance plans. You may be liable for the balance of some treatment costs and are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

I agree to endorse any check to Dr. McDonough if it is payment for his services, even when said payment has been made to a policy holder. Emergency services are frequently paid in full by most policies. However, I understand that by authorizing treatment from a provider that is not participating with my insurance company that I may be using my out-of-network benefits and as a result will be responsible for the remainder of the bill once the claim has been paid by my insurance company.

ASSIGNMENT OF BENEFITS:

I REQUEST THE PAYMENT OF BENEFITS (MEDICARE, MEDICAID, OR OTHER INSURANCE CARRIER) BE MADE DIRECTLY TO MARK D. MCDONOUGH, M.D. FOR SERVICES FURNISHED TO ME BY MARK D. MCDONOUGH, M.D. I AUTHORIZE MARK D. MCDONOUGH, M.D. TO APPLY FOR BENEFIT ON MY BEHALF.

PATIENT/GUARDIAN SIGNATURE

DATE

WITNESS

DATE



Mark D. McDonough, M.D., P.A.

Plastic and Reconstructive Surgery

615 Princeton Street, Suite #540 Orlando, Florida 32803

(407) 896-4440 (407) 896-4410 Fax

Email: mcd@drmcdonough.com • Website: www.drmcdonough.com

PHOTOGRAPHY CONSENT

It is important that you read this information carefully and completely. After reviewing, please sign the consent as proposed by your plastic surgeon.

INTRODUCTION

Medical photographs/slides and videotapes may be taken before, during or after a surgical procedure or treatment. Consent is required to take such images.

Additionally, patients may consent to release these medical photographs/slides and videotapes for a stated purpose.

1. CONSENT TO TAKE PHOTOGRAPHS/SLIDES/VIDEOTAPES

I hereby authorize Mark D. McDonough, M.D. and/or his associates or licensees to take pre-operative, intra-operative and post-operative photographs, slides and/or videotapes. I additionally consent to photographs, slides and/or videotapes of my interview.

2. CONSENT FOR RELEASE OF PHOTOGRAPHS/SLIDES/VIDEOTAPES

I hereby authorize Mark D. McDonough, M.D. and/or his associates or licensees to use pre-operative, intra-operative, and post-operative photographs, slides and/or videotapes for professional medical purposes deemed appropriate. This may include showing these images for purposes of medical education, patient education, lay publication, or during lectures to medical or lay groups. I hereby grant permission for the use of any of my medical records, including illustrations, photographs or other imaging records created in my case, for use in examination, credentialing and/or certifying purposes by the American Board of Plastic Surgery, Inc.

I understand that I will not be entitled to monetary payment or any other consideration as a result of any use of these images and/or my interview.

Date: _____

Patient Signature: _____

Witness: _____