DR. NOEL TENENBAUM, M.D.

PLASTIC & RECONSTRUCTIVE SURGERY

Patient Name _____

Street Address _____

City _____ State _____ Zip _____

Phone Number _____

Date of Birth _____

Allergies to Medication _____

Pharmacy Name _____

Street Address _____

City _____ State _____ Zip _____

OFFICE USE ONLY

ANTIBIOTIC _____

PAIN MED _____

OTHER _____

Sx & Date _____ Sent _____

Sx & Date _____ Sent _____

Sx & Date _____ Sent _____

Sx & Date _____ Sent _____

2626 Tampa Rd. Suite 202, Palm Harbor, FL 34684

DR. NOEL TENENBAUM, M.D.

Phone (727) 786-6921 FAX (727) 266-4086

Plastic & Reconstructive Surgery

www.drtenenbaum.com

PATIENT DEMOGRAPHICS

Last Name_____First Name_____ Age_____

Address_____City_____State_____Zip_____

Email Address_____

Cell Phone_____Birthdate_____

Married_____ Single_____ Widowed _____ Divorced _____

Employer Name _____

Emergency Contact Name_____Phone_____

How did you hear about our practice _____

Referred by_____

Signature _____ Date_____

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HEALTH HISTORY

Name _____ Date _____

Primary Care Physician_____

Reason for Today's Visit_____

Gender _____Age _____ Height _____ Weight _____

Allergies to Medication _____

Any History of the Following:

____Bleeding Disorders/Easy Bruising
____Neurological Disorders
____Asthma
____Chemotherapy/Radiation
____Stomach Problems/GERD
____Thyroid Disease
____Lung Disease
____Religious Beliefs that Affect your Care
____Heart Disease
____Diabetets
____Cancer :Type_____
____High Blood Pressure
____Bladder Disease
____TB, HIV, Hepatitis
____Anxiety, Depression or Psych
____Smoker: PPD _____

List ALL Prescription Medications & Supplements:

Hospitalizations/Surgeries:

_____ Date _____

_____ Date _____

_____ Date _____

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ACKNOWLEDGMENT OF RECEIPT

By my signature below, I acknowledge that I have received the Notice of Privacy Practices from Dr. Noel Tenenbaum M.D.

DATE_____

NAME_____

SIGNATURE _____

This acknowledgement page is retained in the patient's record. If acknowledgement could not be obtained from the patient, the reason (s) must be documented below.

_____

_____

_____

If permission is to be given to speak with a specific family member, it must be documented below.

Name_____

Phone_____

Name_____

Phone_____

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AUTHORIZATION FOR AND RELEASE OF MEDICAL PHOTOGRAPHS/SLIDES AND/OR VIDEOTAPES:

This is a consent document that has beed prepared to help inform you concerning permission to take photographs, slides, and/or videotapes and to use these images for a purpose as defined within this consent document.

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 Dr. Noel Tenenbaum, M.D. and 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 at my consultation.

2. CONSENT FOR RELEASE OF PHOTOGRAPHS/SLIDES/VIDEOTAPES
   I hereby authorize Dr. Noel Tenenbaum, M.D. and his associates or licenses to use pre-operative, intra-operative and post-operative photographs, slides and/or videotapes for professional medical purposes deemed appropriate including but limited to showing these images on public or commercial television, electronic digital networks, for purposes of medical education, patient education, lay publication, or during lectures to medical or lay groups.

I UNDERSTAND THAT I WILL NOT BE ENTITLED TO MONETARY PAYMENT.

DATE_____

PATIENT SIGNATURE _____