The Plastic Surgery Center

Patient Information

Name ____
Last First Middle

Date of Birth ____________________ Age _____Social Security # ______________________ M _____ F______

Single ____ Married ____ Spouse's Name ___________________________Widowed ______ Divorced _______

Occupation ____Employed ______ Retired _______

Emergency Contact: _____________________________Phone: _____________Relationship: ____________

Primary Address: ____
Street

____
City State Zip Code

Secondary Address: ____

____
City State Zip Code

Email Address: ____

Phone (cell)____________________ (work) _______________________ (home)_______________________

Preferred Method of Contact: Home _________ Cell __________ Work __________ Email______________

Person Responsible for payment (if different from patient):

Name: ___________________________________Phone: _______________ Relationship: _______________

Address ____
Street

____
City State Zip Code

How did you hear about our office?

_____ Patient Referral _______ Physician Referral _______ ASPS Website
_____ Internet Search _______ Real Self website ________ Fab Over Fifty website

_____ Other ____

Dr. Jeff Scott has developed a world-renowned reputation in Plastic Surgery. He is recognized for is expertise in achieving beautiful, yet naturally appearing surgical outcomes. Dr. Scott understands the importance of attentive listening and personalized care, consistently achieving exemplary results tailored to the concerns and expectations of each individual patient. As testament to his dedication to patient care, he received "Compassionate Doctor Recognition" 2011-2015, the "Patient Choice Award" for 2011-2015, and the Top Plastic Surgeon Award 2012-2015.

Dr. Scott is certified by the American Board of Plastic Surgery (ABPS). He is a Fellow of the American Society of Plastic Surgeons (ASPS) and a Fellow of the American College of Surgeons (FACS). Dr. Scott received his Bachelor of Science at the University of Oklahoma, where he graduated with Phi Beta Kappa Honors as a three-year varsity tennis letterman. He attained his medical degree at the University of Kansas School of Medicine with top honors (Alpha Omega Alpha). Dr. Scott completed a five-year residency in General Surgery and Trauma followed by a two-year Fellowship in Plastic and Reconstructive Surgery at the Medical College of Virginia. He became board certified in General Surgery in 1990 and Plastic and Reconstructive Surgery in 1993.

Dr. Scott is currently on the medical staff at Manatee Memorial Hospital and Manatee Surgery Center (a facility that has received Joint Commission's Gold Seal of Approval). He is the past Medical Director of the West Florida Surgery Center. He is also a member of the Humera Surgical Society, The Florida Medical Society and the Manatee Medical Society.

With over 22 years of experience, Dr. Jeff Scott specializes in Cosmetic Plastic Surgery. He offers state of the art surgical techniques and noninvasive procedures for body and facial rejuvenation. He performs body contouring surgical procedures, including breast enhancement, reduction and lift, abdominoplasty (tummy tuck), Smart Lipo, liposuction, arm lift, thigh lift, Brazilian Butt Lift, and fat transfer for breast and gluteal enhancement. He also offers Cool Sculpting and SculpSure, noninvasive means of local fat reduction that do not require downtime. His facial surgical expertise includes facelift, brow lift, eyelid surgery, rhinoplasty and chin implants. Less invasive procedures offered are BOTOX Cosmetic, Dysport and dermal fillers which include Juvederm, Voluma, Restylane, Restylane, Silk, and Radiesse. He also provides a variety of laser skin procedures for wrinkles, acne scars and hyperpigmentation.

The Plastic Surgery Center

COMMUNICATION RELEASE FORM

I, ______________________________ would like to communicate via e-mail with The Plastic Surgery Center on matters related to my health and/or my medical treatment. I understand that any Confidential Health Information that I send to the practice is not secure and is sent at my own risk. I will not hold the practice, or any of its workforce members, liable for loss of any confidentiality associated with information transmitted via email. I understand that it is not the policy of the practice to encrypt any Confidential Health information I request to be sent to me via e-mail. Because this information is not encrypted, I understand that it is not secure. I acknowledge this risk and will not hold the practice or any of its workforce members liable for any loss of confidentiality associated with such transmissions.

I would like to receive cosmetic updates, reminders and special promotions (Botox/Dysport/Juvederm/Voluma/Coolsculpt, SculpSure) via email.

__________Yes __________No Email ____

I give permission to be contacted at the following: (check all that may apply)

______________________ Cell Phone ____

______________________ Home Phone ____

______________________ Work Phone ____

____ ______________________

Signature Date

Consent for Use /Disclosure of Health Information

Your personal information is only used to transact the business you have with us. None of your personal or medical information will be used for marketing without your written consent.

By signing this form, you grant us consent to use and disclose your protected health care information for the purposes of treatment, activities associated with payment and health care operations. Our Notice of Privacy Practices provides more details on our treatment, payment activities and health care operations. If there is not a copy of the Notice accompanying this Consent form, please ask for one. We encourage you to read it since it provides details on how information about you may be used and /or disclosed and describes certain rights you have regarding your health care information.

We reserve the right to change our privacy practices. If we should do so, we will issue a revised Notice. Since revisions may apply to your health care information, you have a right to receive a copy.

You have the right to revoke your Consent by giving written notice to our office. You should also understand that if you refuse this Consent we may decline to treat you.

You are entitled to a copy of this Consent Form after you have signed it.

I have read the contents of this Consent Form and the Notice of Privacy Policies. I understand that I am giving you my consent to use and disclose my health care information to carry out treatment, payment activities and health care operations.

_______________________________________ ____________________

Printed Name of Patient Date of Birth

____

Patient's Signature or Signature of Patient's Representative Date

____

Printed Name of Patient's Representative Relationship to Patient

HIPPA Consent for Use/Disclosure of Health Information

This form does not constitute legal advice and covers only federal, not state, laws.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

____

Printed Name

____

Signature

____

Date

The Plastic Surgery Center

Patient Medical Information

NAME: ____ **DATE:** ______________
DATE OF BIRTH: _________________**AGE:** _______ **HEIGHT:** _________ **WEIGHT:**___________
ALLERGIES: ____

Current Prescription Medications

Drug	*Dosage*	*Times/Day*

Current Herbs, Vitamins, Supplements

MEDICAL CONDITIONS:

____
____
____
____

PREVIOUS SURGICAL PROCEDURES: INCLUDE DATES

____
____
____
____
____
____

Primary Care Physician(s)

____