ANDRÉS SÁRRAGA MD FACS
EYES, BREAST & FACIAL REJUVENATION

Name:_____ Date:_____ Age:_____

Date of Birth:_____ Social Security No.:_____

Male/Female Marital Status: Single/Married/Divorced/Widowed

Local Address:_____

City:_____ State:_____ Zip:_____

Permanent Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ E Mail_____

Patient's Occupation:_____
Employer:_____
Address:_____ Phone:_____

Spouse's Name (Parents Name if Patient is a Minor):_____

INSURANCE INFORMATION

Please Note Cosmetic Procedures are Not Covered by Insurance Companies

Responsible Party or Spouse_____

Primary Insurance_____

Policy No.:_____

Secondary Insurance_____

Policy No.:_____

Reason for Consultation:_____

Referred by:_____

May We Send a Thank You Note to the Person(s) Who Referred You? Y N

21110 BISCAYNE BOULEVARD, SUITE 103 | AVENTURA FL 33180
(305) 932-3200 WWW.ANDRESSARRAGAMD.COM

Name:_____Date:_____

Primary Care Physician:_____
Address:_____
City:_____State:_____Zip_____
Cardiologist:_____ Phone:_____
Opthalmologist:_____Phone:_____
Dermatologist:_____Phone:_____

MEDICAL DATA:

Height:_____ Weight:_____

Heart Murmur	No	Yes	Glaucoma	No	Yes
Seizure Disorder	No	Yes	Dry Eyes	No	Yes
Thyroid Disorder	No	Yes	Asthma	No	Yes
Bleeding Disorder	No	Yes	Diabetes	No	Yes
Cold Sores	No	Yes	Bruisability	No	Yes
Abnormal Scars	No	Yes	Stroke	No	Yes
High Blood Pressure	No	Yes	Blood Clots	No	Yes
Irregular Heartbeat	No	Yes	Phlebitis	No	Yes
Immune System Disorder	No	Yes	Arthritis	No	Yes
Hepatitis	No	Yes	Blood Transfusions	No	Yes
Malignant Hyperthermia and/or Family History				No	Yes

Other_____

Date of Previous Surgeries, Serious Illnesses or Injuries (Including Any Cosmetic Procedures:_____

_____

_____Any Complications?_____

Number of Pregnancies:_____Any Complications?_____

Allergies & Sensitivities:_____

Medications and Vitamins you Currently Take:_____

Do You Drink Alcohol? No Yes Frequency_____

Do You Use Recreational Drugs? No Yes Frequency_____

Do You Smoke? No Yes Amount:_____

Did You Ever Smoke:_____Date Stopped:_____

Please Note – Smoking Increases the Risk of Surgery!

VISUAL IMAGES

As a Plastic Surgeon dedicated to improving patient care, Dr. Sarraga emphasizes patient and professional education and understanding. Using "before" and "after" photographs or images is frequently among the best ways to demonstrate the possible benefits or indications for a procedure or technique. Dr. Sarraga kindly asks for your assistance in this process.

VISUAL IMAGE RELEASE FORM

I, _____hereby grant permission to Dr. Andres Sarraga and his staff to take and use visual images or photographs of me. I consent to any of the photographs being used in any manner or media such as lectures, consultations, articles, texts or web sites.

I release Dr. Andres Sarraga and his employees from any liability or damages arising from such use. Dr. Sarraga and his staff shall retain all rights to said materials.

By signing below, I acknowledge that I have read and understand the above and freely give my consent according to the terms of this **Visual Image Release Form.**

☐ Yes, you **may use** my images (photos) to show other patients and/or on a website

☐ I **do not** want my images released

Print Name_____Signature_____

Date_____

(If the patient is a minor, please complete the following):

Patient is a minor, _____years of age, and I/we, the undersigned, are the Parent(s) or guardian(s) of the patient and do hereby consent for the patient.

Patient:_____

Parent(s) or Guardian(s):_____

Date:_____