George P. Zavitsanos, MD

PATIENT INFORMATION

Date of Visit_____

Patient's Name_____Age_____ Date of Birth_____
Home Address_____City_____State_____Zip_____
Home Phone_____Marital Status M D S W
Cell Phone_____ Male__ Female___
Social Security #_____ E-Mail Address _____
Patient's Occupation_____Employer_____
Business Address_____Business Phone_____
Name of Spouse_____Spouse's Occupation_____
Spouse's Employer_____Business Phone_____
Referred By_____
Family Doctor_____Phone_____
Emergency Contact

_____

INSURANCE COVERAGE

Company Name _____ Guarantor Name_____
ID#_____Social Security # _____ Date of Birth_____

Workman's Compensation-Date of Accident_____
Auto Insurance - Date of Accident _____

Insurance Co._____Claim#_____
Insurance Co. Address_____Phone#_____

*****I authorize direct payment of benefits to George P. Zavitsanos, M.D.
I have been informed of the Privacy Notice

Signature _____ Date_____

PATIENT NAME

_____

DATE OF BIRTH

_____

Race: _____ Language: _____ _____

Medications:		Allergies:	
		○ NKA ○ NKDA	
		Smoking History:	
		Smoked 100 cigarettes in lifetime:	○ Yes ○ No
		Current Status:	○ Every day
			○ Some days
			○ Former Smoker
			○ Never Smoker
			○ Unknown
		Current Smokers:	○ Advised to Quit
			○ Gave Cessation Materials/Counseling
		Smokeless Tobacco:	○ Yes ○ No

PHARMACY-
NAME, ADDRESS AND PHONE #
INCLUDING ZIP CODE

_____

_____

_____

HEIGHT _____

WEIGHT _____

PATIENT HEALTH HISTORY

Reason for visit today_____

List any other physicians you may have consulted _____

Are you allergic to any medication(s)_____Yes _____No (If yes, please specify)_____

List all Medications/Vitamins/Herbs/Supplements you are taking and dosage (write "none" if none):

_____

_____

PAST MEDICAL HISTORY/FAMILY HISTORY

DISEASE	Yes	No	Family	DISEASE	Yes	No	Family
Malignant melanoma	___	___	___	Seizures	___	___	___
Basal or Squamous Cell	___	___	___	Eye Disorders	___	___	___
Abnormal Moles	___	___	___	Thyroid Disease	___	___	___
Keloids	___	___	___	Diabetes	___	___	___
High Blood Pressure	___	___	___	Autoimmune Disease	___	___	___
Heart Attack	___	___	___	Blood Disorders	___	___	___
Mitral Valve Prolapse	___	___	___	Hepatitis/HIV	___	___	___
Heart Valve Replacement	___	___	___	Liver Disorders	___	___	___
Pacemaker	___	___	___	Kidney Disease	___	___	___
Edema (leg swelling)	___	___	___	Stomach/Intestinal Disorders	___	___	___
Asthma	___	___	___	Arthritis	___	___	___
Emphysema	___	___	___	Joint Replacement	___	___	___
Shortness of Breath	___	___	___	Depression	___	___	___
Migraine Headaches	___	___	___	Anxiety	___	___	___
Strokes	___	___	___	Cancer (type)_____	___	___	___

List prior surgeries (write "none" if none)

Surgery Date Surgeon's Name

_____

_____

_____

HEIGHT_____ **WEIGHT**_____

What is your approximate consumption?

Coffee/Tea_____ Tobacco_____ Alcohol_____

PATIENT CONSENT FORM

GEORGE P. ZAVITSANOS, M.D.
467 West Pennsylvania Ave, Suite 203
Ft Washington, PA 19034
215-641-2300

PATIENT NAME _____ **DATE OF BIRTH** _____

_____ I hereby authorize *George P Zavitsanos, MD* and/or designated medical staff to leave a detailed message of my laboratory results at the following number: _____

_____ I hereby authorize *George P Zavitsanos, MD* and/or designated medical staff to take photographs as considered necessary for medical records. I understand that these photographs will become part of my medical record and may be shared with other medical professionals.

_____ I understand that tissues/specimens are sent to pathology lab for processing and examination, I (or my insurance company) will be billed separately by the lab. For any questions regarding lab billing, please contact the lab directly.

_____ I understand that my medical care requires my cooperation and I will follow my provider's recommendations. If indicated, I will make and keep appointments for follow up care and call the office to note any concerns or changes in my conditions.

_____ I understand that there are medical procedures that may be necessary as part of my treatment. The following procedures are commonly performed in this office:

Removal of lesions or cysts	Incision and drainage of abcesses
Treatment of benign lesions	Injection of medications into the skin
Treatment of malignant lesions	Scar revision
Skin biopsy for diagnostic purposes	

These are considered minor medical procedures, but they do have associated risks, which may include, but are not limited to: bleeding, infection, scarring, skin color or texture change, numbness, slow healing, allergic reactions, no improvement or partial response to treatment, and / or recurrence. These conditions may either be temporary or permanent. Some of these procedures may require the utilization of a local anesthetic and/or the placement of sutures.

_____ I understand that I have the right to refuse treatment at any time without explanation.

_____ I understand that the response to medical treatment cannot be guaranteed. Additional treatment may be required at additional fees.

I have read and understand the above statements and hereby request and consent to medical care by *George P Zavitsanos, MD* and/or designated medical staff.

_____

Signature of Patient or Legal Guardian **Date**

COVID-19 RISK INFORMED CONSENT

I _____ (patient name) understand that I am opting for an elective treatment/procedure/surgery that is not urgent and may not be medically necessary.

I also understand that the novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. I further understand that COVID-19 is extremely contagious and is believed to spread by person-to-person contact; and, as a result, federal and state health agencies recommend social distancing. I recognize that Dr. ***Zavitsanos*** and all the staff at _____ (practice name) and _____ (facility name) are closely monitoring this situation and have put in place reasonable preventative measures aimed to reduce the spread of COVID-19. However, given the nature of the virus, I understand there is an inherent risk of becoming infected with COVID-19 by virtue of proceeding with this elective treatment/procedure/surgery. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment/procedure/surgery, and I give my express permission for Dr. ***Zavitsanos*** and all the staff at _____ (practice name) and _____ (facility name) to proceed with the same.

I understand that, even if I have been tested for COVID and received a negative test result, the tests in some cases may fail to detect the virus or I may have contracted COVID after the test. I understand that, if I have a COVID-19 infection, and even if I do not have any symptoms for the same, proceeding with this elective treatment/procedure/surgery can lead to a higher chance of complication and death.

I understand that possible exposure to COVID-19 before/during/after my treatment/procedure/surgery may result in the following: a positive COVID-19 diagnosis, extended quarantine/self-isolation, additional tests, hospitalization that may require medical therapy, Intensive Care treatment, possible need for intubation/ventilator support, short-term or long-term intubation, other potential complications, and the risk of death. In addition, after my elective treatment/procedure/surgery, I may need additional care that may require me to go to an emergency room or a hospital.

I understand that COVID-19 may cause additional risks, some or many of which may not currently be known at this time, in addition to the risks described herein, as well as those risks for the treatment/procedure/surgery itself.

I have been given the option to defer my treatment/procedure/surgery to a later date. However, I understand all the potential risks, including but not limited to the potential short-term and long-term complications related to COVID-19, and I would like to proceed with my desired treatment/procedure/surgery.

_____ **Patient Initials**