

# MEDICAL HISTORY FORM

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Date: \_\_\_\_\_

Reason for Visit: \_\_\_\_\_

## MEDICAL ALLERGIES OR SENSITIVITIES

- Do you have any medication or food allergies/sensitivities? ☐ No ☐ Yes

If so, please list: \_\_\_\_\_

- Have you ever had any reaction to latex, rubber, or elastic? ☐ No ☐ Yes

If so, please explain: \_\_\_\_\_

## MEDICATIONS AND DOSAGE (please list all prescribed, ocular, as needed medications, vitamins, and supplement(s))

☐ NONE

- |          |           |           |
|----------|-----------|-----------|
| 1. _____ | 6. _____  | 11. _____ |
| 2. _____ | 7. _____  | 12. _____ |
| 3. _____ | 8. _____  | 13. _____ |
| 4. _____ | 9. _____  | 14. _____ |
| 5. _____ | 10. _____ | 15. _____ |

## OCULAR HISTORY: (Please check box if you currently have or have ever had these conditions)

- |  |  |
|--|--|
| <input type="checkbox"/> Anophthalmia (lost an eye)  | <input type="checkbox"/> Right <input type="checkbox"/> Left |
| <input type="checkbox"/> Amblyopia (lazy eye)        | <input type="checkbox"/> Right <input type="checkbox"/> Left |
| <input type="checkbox"/> ARMD (macular degeneration) | <input type="checkbox"/> Right <input type="checkbox"/> Left |
| <input type="checkbox"/> Cataracts                   | <input type="checkbox"/> Right <input type="checkbox"/> Left |
| <input type="checkbox"/> Glaucoma                    | <input type="checkbox"/> Right <input type="checkbox"/> Left |
| <input type="checkbox"/> Graves' thyroid eye disease | <input type="checkbox"/> Right <input type="checkbox"/> Left |
| <input type="checkbox"/> Retinal detachment          | <input type="checkbox"/> Right <input type="checkbox"/> Left |
| <input type="checkbox"/> Strabismus (crossed eyes)   | <input type="checkbox"/> Right <input type="checkbox"/> Left |

☐ NONE

### STAFF USE ONLY:

BP: \_\_\_\_\_

Pulse: \_\_\_\_\_

OS: \_\_\_\_\_

OD: \_\_\_\_\_

## MEDICAL HISTORY: (Please check box if you currently have or have ever had these conditions)

- |   |   |
|---|---|
| <input type="checkbox"/> Arthritis  | <input type="checkbox"/> Liver Disease (Hepatitis) Type _____                           |
| <input type="checkbox"/> Asthma   | <input type="checkbox"/> Stomach ulcers   |
| <input type="checkbox"/> Thyroid disease  | <input type="checkbox"/> Gastroesophageal reflux disease (GERD)                         |
| <input type="checkbox"/> Cancer Type: _____   | <input type="checkbox"/> Diabetes   |
| Treatment: <input type="checkbox"/> Chemo <input type="checkbox"/> Radiation <input type="checkbox"/> Surgery | <input type="checkbox"/> Kidney Disease   |
| <input type="checkbox"/> Angina (chest pain)  | <input type="checkbox"/> Tuberculosis   |
| <input type="checkbox"/> Irregular heart rhythm or rapid heartbeat (atrial fib, SVT)                          | <input type="checkbox"/> Lung Disease (emphysema / COPD)                                |
| <input type="checkbox"/> High blood pressure (hypertension)   | <input type="checkbox"/> Requires continuous Oxygen                                     |
| <input type="checkbox"/> Heart disease (coronary artery disease or heart attack)                              | <input type="checkbox"/> Obstructive sleep apnea <input type="checkbox"/> Requires CPAP |
| <input type="checkbox"/> Congestive heart failure   | <input type="checkbox"/> Stroke or other Brain injury, Date: _____                      |
| <input type="checkbox"/> HIV  | <input type="checkbox"/> Seizures   |
| <input type="checkbox"/> Bleeding disorders   | <input type="checkbox"/> Anesthesia Complications                                       |
| <input type="checkbox"/> Other _____  |   |
| <input type="checkbox"/> NONE   |   |

Please continue on second page

# MEDICAL HISTORY FORM

## FAMILY HISTORY: Please check any that apply and list family member

- |   |   |
|---|---|
| <input type="checkbox"/> Anesthesia complications _____ | <input type="checkbox"/> Heart disease _____                      |
| <input type="checkbox"/> Bleeding disorders _____       | <input type="checkbox"/> High blood pressure (hypertension) _____ |
| <input type="checkbox"/> Diabetes _____                 | <input type="checkbox"/> Thyroid disease _____                    |

## SURGICAL HISTORY: (please include ALL previous surgeries, even if not listed)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Cataract surgery                          | <input type="checkbox"/> Right <input type="checkbox"/> Left | <input type="checkbox"/> LASIK refractive surgery   |
| <input type="checkbox"/> Glaucoma surgery                          | <input type="checkbox"/> Right <input type="checkbox"/> Left | <input type="checkbox"/> Eyelid surgery             |
| <input type="checkbox"/> Cardiac pacemaker/defibrillator           |  | <input type="checkbox"/> Face Lift                  |
| When was your last check? _____                                    |  | <input type="checkbox"/> Nose surgery (rhinoplasty) |
| <input type="checkbox"/> Coronary artery bypass (CABG) When? _____ |  |   |
| <input type="checkbox"/> Other _____                               |  |   |
| <input type="checkbox"/> NONE                                      |  |   |

## SOCIAL HISTORY:

- Do you smoke?

<input type="checkbox"/> No		
<input type="checkbox"/> Yes	Packs per day _____	How many years? _____
<input type="checkbox"/> Formerly	When did you quit? _____	
- Alcohol use?

<input type="checkbox"/> No		
<input type="checkbox"/> Yes	Frequency <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Rarely	
- Recreational Drug Use?

<input type="checkbox"/> No		
<input type="checkbox"/> Yes	Type: _____	
<input type="checkbox"/> Formerly	When did you quit? _____	

## CURRENT PHYSICIANS:

### **Primary Care Physician**

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ City/State: \_\_\_\_\_

### **Cardiologist (please indicate if applicable)**

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ City/State: \_\_\_\_\_

### **Referring Physician**

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ City/State: \_\_\_\_\_

## Preferred Pharmacy (location you would like us to send any medications prescribed)

Pharmacy Name: \_\_\_\_\_ Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ City/State: \_\_\_\_\_

\_\_\_\_\_  
*Patient Signature*

\_\_\_\_\_  
*Date*

**Patient Information:**

Name:(Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_

☐ Male ☐ Female Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: Cell: \_\_\_\_\_ Home: \_\_\_\_\_

Email: \_\_\_\_\_ May we email you if unable to contact by phone? ☐ Yes ☐ No**Race (please check one):** ☐ American Indian or Alaska Native ☐ Native Hawaiian or other Pacific Islander ☐ Asian☐ White (Caucasian) ☐ Black or African American ☐ Hispanic ☐ Prefer not to disclose**Ethnicity (please check one):** ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Prefer not to disclose

How did you hear about us? \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

May we release medical information to the above Contact? ☐ Yes ☐ No**Primary Insurance Company:** \_\_\_\_\_ Phone: \_\_\_\_\_

Policy ID: \_\_\_\_\_ Group Number: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**Secondary Insurance Company:** \_\_\_\_\_ Phone: \_\_\_\_\_

Policy ID: \_\_\_\_\_ Group Number: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**RELEASE & ASSIGNMENT OF BENEFITS:** I hereby authorize the release of any and all medical information to my insurance carrier(s) or it's/their representative, for purposes necessary in the adjudication or processing of any and all insurance claims filed on my behalf and for which I am financially responsible. I further authorize all insurance benefits be paid to the provider rendering services on behalf of Malena Amato, M.D. or Eyelid and Facial Plastic Surgery Associates. **CONSENT TO TREAT:** I hereby consent to treatment by my physician to include examination and treatment, prescribing medication and procedure preparations. **ACKNOWLEDGEMENT OF RECEIPTS OF NOTICE OF PRIVACY PRACTICES:** I have been given the opportunity to read a copy of this office's Notice of Privacy Practices. I also understand that I have a right to request a copy of the Notice of Privacy Practices for my records. **CONSENT TO ACCESS RX HISTORY:** I voluntarily consent to provide Eyelid and Facial Plastic Surgery Associates access to and use of my prescription medication history from other healthcare providers or third-party pharmacy benefit payors for treatment purposes.

\_\_\_\_\_  
Patient's Signature (Parent if Patient is a minor child)\_\_\_\_\_  
Date



**Patient Financial Policy**

We are pleased you have chosen our practice and are committed to the success of your medical/cosmetic treatment and care. Please initial each of the following regarding your financial responsibility:

1. \_\_\_\_\_ **METHODS OF PAYMENT ACCEPTED:**

Cash, Cashier's Check, ACH, or Venmo @eyelidfpsa

Credit Cards: Visa, MasterCard, Discover, American Express are accepted. ***Collective Credit Card/Debit Card payments \$500 or more will have an additional 4% service charge.***

2. \_\_\_\_\_ If we participate with your managed care plan or you have a commercial insurance plan under which you are covered, we will bill your insurance(s) for all charges for services rendered. You will be responsible at the time of service for the payment of:

- Co-Payments
- Annual Deductible
- Charges for non-covered or cosmetic services

3. \_\_\_\_\_ If you have no health insurance, payment is expected in full at the time of service.

4. \_\_\_\_\_ In the event we receive a returned check due to insufficient funds, a fee of \$35.00 will be charged to your account and payment is due upon receipt of your statement.

5. \_\_\_\_\_ We request that you give 24-hour notice if you are unable to keep your appointment. Failure to give 24-hour notice will result in a \$35.00 missed appointment fee. This fee is not covered by your insurance company.

6. \_\_\_\_\_ Cosmetic Surgery Consultation fees are \$250. This fee is due at the time of scheduling your consultation in advance of your appointment.

Your signature below signifies that you understand our financial policy and your responsibility regarding charges incurred in our office.

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date



**Photographic Release and Current Physicians**

Patient: \_\_\_\_\_ DOB: \_\_\_\_\_

I authorize Eyelid and Facial Plastic Surgery Associates to take pre-, intra-, and post- operative photos during the course of my evaluation and treatment.

I understand that the photos may be stored on electronic or paper medical records. Whenever possible, patient identifying features will be excluded.

I approve the photos to be used for the following purposes (please check Yes or No for each):

- |  |  |
|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Clinical Documentation/Insurance Authorization   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Educational activities directed at patients and other physicians   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Presentations to medical and non-medical organizations   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Publication in medical journals  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Marketing purposes such as brochures, educational pamphlets, website, and social media platforms (e.g., Instagram, Facebook) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | In-office photo gallery display (photos viewable only within the office setting)   |

I understand my clinical care will not be affected by my choice to authorize or not authorize use of photographs for the above stated purpose.

I hereby release and hold harmless the authorized parties of and from any and all claims, demands, damages or causes of action in connection with the use of the photographs I have hereby authorized.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date