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)

☐ Anophthalmia (lost an eye) ☐ Right ☐ Left
☐ Amblyopia (lazy eye) ☐ Right ☐ Left
☐ ARMD (macular degeneration) ☐ Right ☐ Left
☐ Cataracts ☐ Right ☐ Left
☐ Glaucoma ☐ Right ☐ Left
☐ Graves' thyroid eye disease ☐ Right ☐ Left
☐ Retinal detachment ☐ Right ☐ Left
☐ Strabismus (crossed eyes) ☐ Right ☐ Left
☐ **NONE**

STAFF USE ONLY:

BP: _____
Pulse: _____
OS: _____
OD: _____

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

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

Please continue on second page

MEDICAL HISTORY FORM

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

☐ Anesthesia complications _____
☐ Bleeding disorders _____
☐ Diabetes _____
☐ Heart disease _____
☐ High blood pressure (hypertension)_____
☐ Thyroid disease_____

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

☐ Cataract surgery ☐ Right ☐ Left
☐ Glaucoma surgery ☐ Right ☐ Left
☐ Cardiac pacemaker/defibrillator
When was your last check? _____
☐ Coronary artery bypass (CABG) When? _____
☐ LASIK refractive surgery
☐ Eyelid surgery
☐ Face Lift
☐ Nose surgery (rhinoplasty)
☐ Other _____
☐ NONE

SOCIAL HISTORY:

- Do you smoke? ☐ No ☐ Yes Packs per day _____ How many years? _____ ☐ Formerly When did you quit? _____
- Alcohol use? ☐ No ☐ Yes Frequency ☐ Daily ☐ Weekly ☐ Rarely
- Recreational Drug Use? ☐ No ☐ Yes Type: _____ ☐ 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*

EYELID & FACIAL PLASTIC SURGERY ASSOCIATES

MALENA AMATO MD FACS

MARIE SOMOGYI MD FACS

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

EYELID & FACIAL PLASTIC SURGERY ASSOCIATES

MALENA AMATO MD FACS
MARIE SOMOGYI MD FACS

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 48-hour notice if you are unable to keep your appointment. Failure to give 48-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 covers the cost of the surgical consultation and evaluation with the surgeon. This fee is due at the time of scheduling your consultation in advance of your appointment and may later be applied toward a surgical procedure once scheduled. *This fee may only be refunded if the appointment is canceled with more than a 48-hour notice.*

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

_____ _____

Patient/Guardian Signature Date

Effective 1/1/2023

EYELID & FACIAL PLASTIC SURGERY ASSOCIATES

MALENA AMATO MD FACS
MARIE SOMOGYI MD FACS

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 of No for each):

☐ Yes ☐ No	Clinical Documentation/Insurance Authorization
☐ Yes ☐ No	Educational activities directed at patients and other physicians
☐ Yes ☐ No	Presentations to medical and non-medical organizations
☐ Yes ☐ No	Publication in medical journals
☐ Yes ☐ No	Marketing purposes such as brochures, educational pamphlets, website, and social media platforms (e.g., Instagram, Facebook)
☐ Yes ☐ 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