

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 _____ | |

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?
 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



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 and Co-insurance
- Annual Deductible
- Charges for non-covered or cosmetic services
- Post-operative visits are covered for 90 days after the date of surgery. Appointments outside the insurance global period are billed to the insurance as an office visit and patient responsibility applies.

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



Photographic Release

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