

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 | ☐ Liver Disease (Hepatitis) Type _____ |
| ☐ Asthma | ☐ Stomach ulcers |
| ☐ Thyroid disease | ☐ Gastroesophageal reflux disease (GERD) |
| ☐ Cancer Type: _____ | ☐ Diabetes |
| Treatment: ☐ Chemo ☐ Radiation ☐ Surgery | ☐ Kidney Disease |
| ☐ Angina (chest pain) | ☐ Tuberculosis |
| ☐ Irregular heart rhythm or rapid heartbeat (atrial fib, SVT) | ☐ Lung Disease (emphysema / COPD) |
| ☐ High blood pressure (hypertension) | ☐ Requires continuous Oxygen |
| ☐ Heart disease (coronary artery disease or heart attack) | ☐ Obstructive sleep apnea ☐ Requires CPAP |
| ☐ Congestive heart failure | ☐ Stroke or other Brain injury, Date: _____ |
| ☐ HIV | ☐ Seizures |
| ☐ Bleeding disorders | ☐ 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 _____ | ☐ Heart disease _____ |
| ☐ Bleeding disorders _____ | ☐ High blood pressure (hypertension) _____ |
| ☐ Diabetes _____ | ☐ Thyroid disease _____ |

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

- | | | |
|--|--|---|
| ☐ Cataract surgery | ☐ Right ☐ Left | ☐ LASIK refractive surgery |
| ☐ Glaucoma surgery | ☐ Right ☐ Left | ☐ Eyelid surgery |
| ☐ Cardiac pacemaker/defibrillator | | ☐ Face Lift |
| When was your last check? _____ | | ☐ Nose surgery (rhinoplasty) |
| ☐ Coronary artery bypass (CABG) When? _____ | | |
| ☐ 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



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. Cosmetic Surgery Revision Consultations fees are \$500. 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):

- | | |
|--|--|
| ☐ 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