AESTHETIC EYE, PC

Oculofacial Plastic & Reconstructive Surgery

Today's Date: _____

Patient Information

Last Name | First Name | MI | Date of Birth

Mailing Address | City | State | Zip Code

( ) Primary Phone Number | ( ) Secondary Phone Number | May we leave a message? Yes ☐ No ☐

Email Address

Preferred Language | Race | Ethnicity

Occupation | Employer | Social Security Number

Emergency Contact | ( ) Phone Number | Relationship

Did your physician refer you? If yes, whom? Yes ☐ No ☐

May we discuss your medical information with anyone? Yes ☐ No ☐

If yes, whom? (please specify relationship)

Insurance Information

Primary Insurance Company | Policy ID Number

Policy Holder (full name as stated on insurance card) | Relation to Subscriber

Secondary Insurance Company | Policy ID Number

Policy Holder (full name as stated on insurance card) | Relation to Subscriber

How did you hear about us? Patient ☐ Social Media ☐ Other ☐

Would you like to receive promotional emails? Yes ☐ No ☐

Reason for visit	
	Duration
Right Eye ☐ Left Eye ☐ Both ☐	
Have you had previous treatment for this condition? Yes ☐ No ☐	
If yes, when and with who was treatment administered?	

Do you have or have you ever had any of the following? Please mark all either YES or NO.

	No	Yes	Controlled by Medication?	Explain
Neurological				
Headaches				
Paralysis/weakness				
Alzheimer's or Dementia				
Parkinson's Disease				
Numbness or tingling				
Other (please specify)				
Cardiovascular				
Heart disease/heart attack				
High blood pressure				
Bleeding/clotting disorder				
Stroke				
High cholesterol				
Chest pain				
Irregular heartbeat				
Pacemaker				
Congestive Heart Failure				
Other (please specify)				
Endocrine				
Diabetes (type I or II)				
Hypothyroid				
Hyperthyroid				
Liver problems/liver disease				
Other (please specify)				
Skin				
Do you have a tendenancy to scar or form keloids?				
Skin cancer (please state type and location)				
Infectious Disease				
HIV				
Hepatitis (A, B, or C)				
History of MRSA				
Cancer				
Pregnant or nursing?				

Do you have or have you ever had any of the following? Please mark all either YES or NO.

	No	Yes	Controlled by Medication?	Explain
Musculoskeletal				
Joint pain				
Artificial joints				
Limited motion				
Muscle weakness				
Other (please specify)				
Constitutional Symptoms				
Epilepsy or seizures				
Fainting				
Fever or chills				
Unexpected weight loss/gain				
Ear, nose, mouth, and throat				
Sinus disorder				
Facial trauma or injury				
Other (please specify)				
Urinary				
Bladder problems				
Frequent/burning urination				
Kidney problems				
Other (please specify)				
Gastrointestinal				
Digestive problems				
Ulcers				
Other (please specify)				
Hematologic and Lymphatic				
Anemia				
Have you ever had a blood transfusion(s)?				
Other (please specify)				
Mental Health				
Depression				
Anxiety				
Attention-deficit disorder				
Developmental delay or disorder				
Other (please specify)				
Respiratory				
Sleep Apnea (CPAP use?)				
Asthma				
Bronchitis/wheezing				
Emphysema/COPD				
Shortness of breath				
Pulmonary embolus				
Tuberculosis				

Do you have or have you ever had any of the following? Please mark all either YES or NO.

	No	Yes	Controlled by Medication?	Explain
Past Eye History				
Retinopathy				
Glaucoma				
Keratopathy				
Cataract				
Macular Degeneration				
Other (please specify)				

Surgeries or Hospitalizations	
Procedure	Year
Ocular Surgeries	

Family History			
	No	Yes	Family Member
Unknown or adopted			
Autoimmune disorders			
Colon Cancer			
Diabetes			
Glaucoma			
High Blood Pressure			
High Cholesterol			
Liver Disease			
Lung Disease			
Malignant Melanoma			
Obesity			
Premature Coronary/Heart Disease			
Skin Cancer			
Thyroid Disease			

Social History								
Alcohol Use	Yes	☐	No	☐	Daily	☐	Occasionally ☐	Rarely ☐
Smoking	Yes	☐	No	☐	Quit	☐	Year:	
Recreational Drug use	Yes	☐	No	☐	Quit	☐	Year:	

Patient's Pharmacy			
Name	Cross Streets	City	Phone Number

Current Medications		
Medication	Dosage	Prescribed by

Allergies	
Medication	Reaction
Latex allergy? Yes ☐ No ☐	

Provider Information	
Primary Care Provider	
Cardiologist	

Please list ALL of your Medical History and Conditions

Authorization	
To the best of my knowledge, the above information is complete and correct. I understand that reporting incomplete or inaccurate information can be dangerous to my health. I understand that it is my responsibility to inform Aesthetic Eye, PC should any of the above information change.	
Signature of patient or responsible party (please state relationship)	Date
Name of patient or responsible party (please state relationship)	Date

AESTHETIC EYE, PC
EST° 2011
OCULOFACIAL PLASTIC & RECONSTRUCTIVE SURGERY

Financial Guarantee:

I give my permission to Aesthetic Eye, PC to bill my insurance company whether the benefits are to come to me or Aesthetic Eye, PC. It is my understanding that I am eligible for medical benefits through my insurance. In the event that my insurance company categorizes services rendered to me as "non-covered" or "not medically necessary," I agree to pay in full for all such charges.

I understand that it is my responsibility to advise Aesthetic Eye, PC if my insurance requires pre-admission review, pre-admission authorization, a second opinion, or it contains any special provisions which must be satisfied before payment by the insurance company can be made. If I fail to advise Aesthetic Eye, PC of such policy requirements I agree to pay in full for all such charges.

If I am a member of a managed care plan or a health maintenance organization, I understand that it is in my responsibility to ensure that the correct referral is in place from my Primary Care Provider. I understand that I will be responsible for any and all charges at the time of service should a referral not be in place from my Primary Care Provider.

I understand that copayment is due at the time of service. Please be advised that some insurance companies have a specialist copayment, as such, the specialist copayment will be collected.

I understand and accept full responsibility for any fees incurred in the collection of this account, including legal fees, should this account become delinquent and/or turned over to our collection agency.

Cancellation Policy:

We are glad to have you as our patient, and we want to provide you with a safe and relaxed environment.

Cancellation policy for our insurance appointments:

So, we can serve as many patients as possible, we ask for ample time if you need to cancel or reschedule your appointment for any reason. A cancellation fee of $50 will be assessed for appointments canceled less than 48 business hours prior to your appointment. A fee of $200 will be assessed for surgeries canceled less than 10 days prior to the scheduled surgery date.

Deposits and cancellation policy for our cosmetic appointments:

A non-refundable deposit of $100.00 will be collected prior to scheduling your appointment.

A cancellation fee of $100.00 will be assessed for appointments canceled less than 48 business hours prior to your appointment. A fee of $200 will be assessed for surgeries canceled less than 10 days prior to the scheduled surgery date.

$100.00 deposit is to reserve your appointment and goes towards your treatment, should you elect to have treatment.

The signature below authorizes direct assignment of benefits to Aesthetic Eye, PC as well as acknowledgment of the cancellation policy:

_____

Signature of patient or responsible party

_____ _____

Name of patient or responsible party Date

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Consent for Use and Disclosure of Health Information:

I,_____, authorize Aesthetic Eye, PC to use and disclose the health and medical information for the purposes of treatment, payment and healthcare operations.

- Treatment: Includes activities performed by a physician, nurse, office staff, and other types of health care professionals providing care to you. This is to include coordination or management of your care with third parties and consultations with and between other health care providers. This consent includes treatment provided by any physician who covers our practice by telephone as the on-call physician.
- Payment: Includes activities involved in determining your eligibility for health plan coverage, billing, and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, precertification and preauthorization.
- Health Care Operations: Includes the necessary administrative and business functions of our office.

Notice of Privacy Practices:

You may review the Notice of Privacy Practices for Aesthetic Eye, PC for additional information about the uses and disclosures of information described in this consent prior to signing below. If you would like to view this please ask the receptionist for a copy.

You have the right to request restrictions on how we use and disclose your protected health information for treatment, payment and health care operations purposes. Please be aware that we are not required to agree to your request. If we do agree, we are required to comply with your request unless the information is needed to provide you emergency treatment. Other physicians who provide call coverage for our office are required to use and disclose your protected health information consistent with the notice of privacy practices.

The below signature acknowledges the above statements:

_____

Signature of patient or responsible party

_____ _____

Name of patient or responsible party Date