SAN DIEGO EYELID SPECIALISTS

PATIENT DEMOGRAPHICS

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Last Name: _____ First Name: _____ Middle Name: _____

SSN: _____ DOB: _____ Age: _____ Sex: Male / Female

Home Phone: _____ Mobile Phone: _____ Other: _____

Preferred: Home / Mobile / Other **Is it okay to leave you a detailed message?** YES / NO

Address:_____ City: _____ State: _____ Zip:_____

Email Address: _____ **E-mail Notification:** YES / NO

EMERGENCY CONTACT

Name: _____ Relationship:_____ Phone:_____

INSURANCE INFORMATION

Name of Insured (**If different from patient name**): _____ Insured DOB: _____

Primary Insurance:_____ ☐ Self ☐ Spouse ☐ Other Policy/ID: _____

Secondary Insurance:_____ ☐ Self ☐ Spouse ☐ Other Policy/ID: _____

OTHER INFORMATION

Referred by: _____ Primary Care Physician:_____

Reason for appointment: _____

CONSENT FOR PHOTOGRAPHY

I hereby authorize Dr. Srinivas Iyengar and his associates to take photographs, slides and/or digital imaging appropriate to my procedure. I further authorize the use of photographs, slides, and/or imaging for professional medical purposes, while maintaining my confidentiality, deemed appropriate including but not limited to showing the photos, slides and/or imaging on all electronic media, or using the photographs, slides and/or imaging for purposes of medical publication, medical education, patient education or during lectures to medical or lay groups and for the use in examination.

☐ **ACCEPT**, I understand that I will not be entitled to any payment or other form of remuneration as a result of any use of photographs, slides and/or imaging of my procedure and/or the interview concerning that procedure.

☐ **DECLINE**, I wish for these photographs to remain in my medical record only and not to be used for any other purposes.

X _____ _____

Signature of Patient/Guardian **Date**

PRIVACY POLICY

I hereby acknowledge that I reviewed a copy of the medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current will be posted in the reception area, and that a copy of my amended Notice of Privacy Practices will be available at each appointment.

I wish to receive a copy of the privacy practices policy by ☐ print ☐ email ☐ website ☐ I do not wish to receive a copy

X _____ _____

Signature of Patient/Guardian **Date**

RELEASE OF HEALTH RECORDS

I hereby authorize San Diego Eyelid Specialists to release my health information such as medical diagnosis, treatment, prognosis, and other pertinent data and to discuss my care with the following named person(s).

Name: _____ Relationship: _____

Name: _____ Relationship: _____

X _____ _____

Signature of Patient/Agent/Guardian **Date**

FINANCIAL AGREEMENT

As a service and courtesy to you, we are happy to file your insurance claims. However, please remember that your insurance contract is between you, your employer, and the insurance company. Insurance is considered a method of reimbursing the patient fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance. It is also your responsibility to notify us of any changes in your health insurance.

I authorized San Diego Eyelid Specialists, INC. to bill my insurance for services renders to me or my dependent. I understand that I am financially responsible for all charges for services provided by San Diego Eyelid Specialists, INC. whether or not they are covered or paid by my health insurance for any reason. If insurance is not applicable, you will be financially responsible for all rendered services.

X _____ _____

Signature of Patient/Guardian **Date**

MEDICAL HISTORY

PREFERRED PHARMACY: _____

Street: _____ City/State/Zip: _____

ALLERGIES

Please list any known drug, food, or environmental allergies below.

CURRENT MEDICATIONS

Please list any medications you are currently taking, including over-the-counter and supplements.

OCULAR HISTORY

Do you have or have you had any of the following ocular conditions?		
Cataract	Yes	No
Macular Degeneration	Yes	No
Glaucoma	Yes	No
Ocular Surgery	Yes	No

Please list any ocular surgery: _____

_____

_____

SOCIAL HISTORY

What is your smoking history? **Check the box that applies.**	
I have never smoked.	
I used to smoke.	
I currently smoke. How many packs a day?	

What is your alcohol intake? **Check the box that applies.**	
I do not drink alcohol.	
I have < 1 drink a day.	
I have 1-2 drinks a day.	
I have > 2 drinks a day.	

PAST SURGICAL PROCEDURES

List any surgical procedures you've had and the approximate year:

_____

_____

_____

PERSONAL MEDICAL HISTORY

Do you have or have had any of the following medical conditions? **Check the boxes that apply.**			
Hypertension		Kidney Disease	
Heart Disease		Hepatitis	
Stroke		Cancer	
Diabetes		Thyroid Disease	
Asthma		Osteoporosis	
Emphysema		Arthritis	
Peptic Ulcers			

FAMILY MEDICAL HISTORY

Have any of your blood relatives (living or deceased) had any of these conditions? **Check the boxes that apply and list which relative. i.e. f-father, m-mother, s-sister, b-brother, etc.**			
Hypertension		Kidney Disease	
Heart Disease		Hepatitis	
Stroke		Cancer	
Diabetes		Thyroid Disease	
Asthma		Osteoporosis	
Emphysema		Arthritis	
Peptic Ulcers			

List any <u>other</u> medical conditions you have below:_____

_____

_____

OTHER HISTORY - ***If 60 years of age or older:***

Have you had a pneumonia vaccine?	Yes	No
Do you have a healthcare proxy in the event you can't make medical decisions?	Yes	No
Do you have a living will?	Yes	No

Which statement best reflects your wishes on advanced care recommendation?	
Do Not Intubate	
Do Not Resuscitate	
Full Cardiopulmonary Resuscitation	