NEW PATIENT INFORMATION

PERSONAL INFORMATION (Please Print)

Name_____ Date_____

Date of Birth_____Age_____M/F____ Soc. Security # _____

Address_____

Street City State Zip

Phone: Home #_____ Work #_____Cell# _____

Employer_____ Occupation_____

Address_____ Phone#_____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Spouse Name _____ Employer_____

Address _____ Employer Phone #_____

Referred by: ☐ Friend/Relative _____Doctor_____

☐ Yellow Pages ☐ Television ☐ Newspaper ☐ Other_____

Preferred Pharmacy address and phone number_____

_____

Complete if Under 18 years or a student

Name of Father_____ Employer _____

Date of birth _____ Soc. Security #_____

Address _____Phone #_____

Name of Mother_____ Employer _____

Date of Birth _____Soc. Security_____

Address _____ Phone #_____

INSURANCE INFORMATION

Medicare # _____ Medicaid # _____

Workers Compensation (job injury) to whom is bill to be sent? _____

Other Medical Insurance _____

ID# _____ Group # _____

2nd Insurance _____

ID# _____ Group # _____

Are you personally responsible for the payment of your fees? ☐ Yes ☐ No If not, who is?

Name _____Relationship _____

Address_____

Home_____ Phone_____

Work#_____

By signing up for Email, you consent to receive electronic communications, promotional offers, event notices and other materials from Idaho Eyelid & Facial Plastic Surgery. If you have any questions, or should you wish to withdraw your consent at any time, please feel free to contact us 208-344-3220. You may also opt out of our emails at any time by clicking the unsubscribe link at the bottom of any email from us.

Signed _____ Email Address _____

☐ I would **ONLY** like to receive emails regarding my account and appointments.

FINANCIAL ASSIGNMENT AND AGREEMENT

1. **We always request payment at time of service**. **If appointment is missed without 24 hour notice there is a $50.00 charge.**
2. Please remember that insurance is considered a method of reimbursing the patient for 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.
3. In order to control your cost of billings, we request that your charges for office visits, including deductibles & copays, be paid at the conclusion of each visit. If we are required to use Collection Bureau there is up to 18% interest.
4. I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information about me to be released to the Health Care Financing Administration, its agents, or any insurance carrier who may have any information needed to determine these benefits or the benefits payable for related services.
5. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.
6. I was offered a copy of Idaho Eyelid & Facial Plastic Surgury, PLLC's HIPAA Privacy Act effective date 9/23/2013.

Signed (Patient or parent if minor) _____Date _____

PATIENT MEDICAL HISTORY RECORD: FORM B

PATIENT NAME:_____ DATE:_____

MEDICAL STATUS AND HISTORY

1. HAVE YOU EVER BEEN TREATED FOR ANY MEDICAL CONDITIONS (E.G., DIABETES, HIGH BLOOD PRESSURE, ARTHRITIS, ETC.)?

YES NO

YES, PLEASE EXPLAIN:_____

_____

2. HAVE YOU EVER BEEN DIAGNOSED WITH **SLEEP APNEA** OR DO YOU USE A **C-PAP MACHINE**? YES NO

YES, PLEASE EXPLAIN:_____

3. HAVE YOU HAD PREVIOUS SURGERIES YES NO

YES, PLEASE LIST_____

4. DO YOU TAKE ANY MEDICATIONS? YES NO

YES, PLEASE LIST_____

_____

5. DO YOU TAKE ANY EYE MEDICATIONS? YES NO

YES, PLEASE LIST_____

6. DO YOU HAVE ANY DRUG ALLERGIES YES NO

YES, PLEASE LIST _____

7. HAVE YOU HAD ANY EYE INJURIES OR OPERATIONS? YES NO

YES, PLEASE LIST _____

_____

8. DO YOU HAVE A SENSITIVITY OR ALLERGY TO LATEX? YES NO

9. **DO YOU HAVE ANY FOOD ALLERGIES?** YES NO

PLEASE LIST _____

REVIEW OF SYSTEMS

DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING PROBLEMS?

CHRONIC FEVER, UNEXPECTED WEIGHT LOSS/GAIN, FATIGUE Y N

EXPLAIN _____

EAR/NOSE/THROAT PROBLEMS (E.G., HEARING LOSS, SINUS PROBLEMS, SORE THROAT Y N

EXPLAIN_____

HEART PROBLEMS (E.G., CHEST PAIN, IRREGULAR HEART BEAT) Y N

EXPLAIN_____

RESPIRATORY PROBLEMS (EG., SHORTNESS OF BREATH, WHEEZING, COUGHING) Y N

EXPLAIN_____

REVIEW OF SYSTEMS (CONTINUED)

GASTROINTESTINAL PROBLEMS (EG., HEARTBURN, ABDOMINAL PAIN, DIARRHEA) Y N

EXPLAIN _____

URINAL PROBLEMS (E.G., PAIN OR DISCOMFORT, BLOOD IN URINE) Y N

EXPLAIN_____

SKIN PROBLEMS (EG., RASHES, EXCESSIVE DRYNESS) Y N

EXPLAIN_____

MUSCULOSKELETAL PROBLEMS (E.G., MUSCLE ACHES, JOINT PAIN, SWOLLEN JOINTS Y N

EXPLAIN_____

NEUROLOGIC PROBLEMS (EG., NUMBNESS, WEAKNESS, HEADACHES, PARALYSIS) Y N

EXPLAIN_____

PSYCHIATRIC PROBLEMS (E.G., DEPRESSION, ANXIETY) Y N

EXPLAIN_____

DO YOU SMOKE? Y N HOW MUCH? _____ DO YOU DRINK? Y N HOW MUCH? _____

FAMILY HISTORY

DO ANY MEDICAL OR EYE DISEASES RUN IN YOUR FAMILY (E.G,) DIABETES, HIGH BLOOD PRESSURE, CANCER, GLAUCOMA, MACULAR DEGENERATION)?

_____

_____

REASON FOR TODAYS EXAM

_____

_____

Idaho Eyelid & Facial Plastic Surgery is committed to protecting the privacy of your personal information. We are required by applicable federal and state laws to maintain the privacy of your personal and health information. This notice explains our privacy practices, our legal duties, and your rights concerning your personal and health information. Personal and health information means any information that is identifiable to you as your personal information, including information regarding your health care and treatment; identifiable factors including your name, age, address, income or other financial information.

I acknowledge that I have been informed by Idaho Eyelid & Facial Plastic Surgery PLLC, that upon my request, I will be furnished with a Notice of Privacy Practices.

Signed (Patient or parent if minor) _____ Date _____

Relationship (Patient or parent if minor) _____