NEW PATIENT INFORMATION

PERSONAL INFORMATIOIN (PLEASE PRINT)

NAME: _____ DATE OF BIRTH: _____ DATE: _____
AGE: _____ GENDER: □ MALE □ FEMALE □ OTHER: _____ SSN: _____
ADDRESS: _____
PRIMARY PHONE#: _____ SECONDARY PHONE#: _____
EMPLOYER: _____ OCCUPATION: _____
EMPLOYER ADDRESS: _____ PHONE #: _____
MARITAL STATUS: □ SINGLE □ MARRIED □ WIDOWED □ DIVORCED □ OTHER: _____
SPOUSE NAME: _____ PHONE #: _____
REFERRAL SOURCE: □ FRIEND/RELATIVE _____ □ PROVIDER: _____
□ YELLOW PAGES □ NEWSPAPER □ FACEBOOK □ INSTAGRAM □ GOOGLE SEARCH □ SPA: _____ □ OTHER:_____
PREFERRED PHARMACY: _____
PLEASE COMPLETE IF UNDER 18 YEARS OF AGE
NAME OF LEGAL GUARDIAN: _____ EMPLOYER: _____
DATE OF BIRTH: _____ SSN: _____ PHONE #: _____
ADDRESS: _____

INSURANCE INFORMATION

□ MEDICARE (ONLY) □ MEDICARE WITH SUPPLEMENT □ MEDICARE REPLACEMENT PLAN □ MEDICAID □ TRICARE/VA
□ COMMERCIAL INSURANCE □ WORKER'S COMPENSATION: _____
NAME OF PRIMARY INSURANCE: _____
POLICY #: _____ GROUP #: _____
NAME OF SECONARY INSURANCE: _____
POLICY #: _____ GROUP #: _____
GUARANTOR INFORMATION (PERSON RESPONSIBLE FOR PAYMENT): □ SELF □ LEGAL GUARDIAN: _____
□ OTHER: _____
NAME: _____ RELATIONSHIP: _____ PHONE #: _____

EMAIL SIGN UP

By signing up for E-mail, you consent to receive electronic communications, promotional offers, event notices and other material from Idaho Eyelid & Facial Plastic Surgery. You may opt out of our E-mails at any time by clicking the unsubscribe link at the bottom of any E-mail.

Signature: _____ E-mail Address: _____
□ I would **ONLY** like to receive emails regarding my account and appointments.

FINANCIAL AGREEMENT

1. Payment will be requested at time of service. If an appointment is missed without sufficient notice (1 business day), a **$100** fee will be applied.
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, co-insurance, copay or 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, co-insurance, and copayments be paid at the conclusion of each visit. If we are required to use a collection agency, there is an interest charge of up to 18%.
4. By signing below you are requesting that payment of authorized Medicare and/or insurance benefits be made on your behalf for any services rendered. You are also authorizing any holder of medical information about you 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 the signee in writing. A photocopy of this assignment is to be considered as valid as an original. By signing below, I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize Idaho Eyelid & Facial Plastic Surgery to release all information necessary to secure payment for services rendered.

SIGNATURE: _____ DATE: _____

PATIENT NAME: _____ DATE: _____

MEDICAL HISTORY AND STATUS

CHECK ALL MEDICAL CONDITIONS YOU'RE BEING TREATED FOR:

□ DIABETES □ HIGH BLOOD PRESSURE □ ARTHRITIS
□ A-FIB □ SLEEP APNEA □ THYROID PROBLEMS
□ GOUT □ CHOLESTEROL PROBLEMS □ ASTHMA
□ OTHER: _____

LIST ANY PREVIOUS SURGERIES YOU'VE HAD: _____
_____
_____
_____

LIST ANY EYE SURGERIES YOU'VE HAD: _____
_____
_____
_____

DO YOU HAVE A LATEX ALLERGY? □ YES □ NO
DO YOU HAVE ANY FOOD ALLERGIES? □ YES □ NO
PLEASE LIST: _____
_____

REVIEW OF SYSTEMS (CHECK ALL THAT APPLY)

EAR/NOSE/THROAT
□ HEARING LOSS
□ SINUS PROBLEMS
□ SORE THROAT
□ OTHER: _____

HEART PROBLEMS
□ CHEST PAIN
□ IRREGULAR HEART BEAT
□ STENTS
□ OTHER: _____

RESPIRATORY PROBLEMS
□ SHORTNESS OF BREATH
□ WHEEZING/COUGING
□ ASTHMA
□ OTHER: _____

GASTROINTESTINAL PROBLEMS
□ HEARTBURN
□ ABDOMINAL PAIN
□ DIARRHEA
□ OTHER: _____

URINAL PROBLEMS
□ PAIN/DISCOMFORT
□ BLOOD IN URINE
□ FREQUENT UTI'S
□ OTHER: _____

SKIN PROBLEMS
□ RASHES
□ EXCESSIVE DRYNESS
□ LESIONS
□ OTHER: _____

NEURO PROBLEMS
□ NUMBNESS/WEAKNESS
□ HEADACHES/MIGRAINES
□ PARALYSIS
□ OTHER: _____

MUSCULOSKELETAL PROBLEMS
□ MUSCLE ACHES
□ JOINT PAIN/SWOLLEN JOINTS
□ ARTHRITIS
□ OTHER: _____

PSYCHIATRIC PROBLEMS
□ DEPRESSION
□ ANXIETY

OTHER HEALTH PROBLEMS
□ BLOOD CLOTS
□ COLD SORES

DO YOU HAVE ANY OTHER HEALTH CONDITIONS? □ YES □ NO

MEDICATIONS

PLEASE LIST ALL MEDICATIONS WITH DOSE AND FREQUENCY:

LIST ALL EYE DROPS YOU USE:

LIST ALL MEDICATION ALLERGIES:

PLEASE LIST:

_____
_____
_____
_____
_____
_____

WHO IS YOUR CURRENT PRIMARY CARE PHYSICIAN? _____

DO YOU USE ANY TOBACCO PRODUCTS? (CHECK ALL THAT APPLY)
□ CIGARETTES: HOW MUCH? _____
□ CIGARS: HOW MUCH? _____
□ CHEWING TOBACCO
□ VAPE

DO YOU DRINK ALCOHOL? □ YES □ NO
HOW OFTEN? _____

DO ANY MEDICAL OR EYE CONDITIONS RUN IN YOUR FAMILY? (CHECK ALL THAT APPLY)
□ DIABETES □ HIGH BLOOD PRESSURE □ CANCER
□ GLAUCOMA □ MACUALR DEGENERATION
□OTHER: _____

WHAT ARE WE SEEING YOUR FOR TODAY? (CHECK ALL THAT APPLY)
□ DROOPY EYELIDS □ TEARING □ EYELIDS TURN OUT □ EYELIDS TURN IN
□ BUMP/LESION ON EYELID □ EYE PAIN □ DOUBLE VISION □ EYE PROTRUSION
□ OTHER (PLEASE DESCRIBE):

_____
_____
_____

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. Including; your personal information, information regarding your healthcare 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 to patient _____

Authorization to release medical information to someone other than yourself (please write name and relation):

Name: _____ Relation: _____
Name: _____ Relation: _____