NEW PATIENT INFORMATION

PERSONAL INFORMATION (PLEASE PRINT)

NAME: _____ DATE OF BIRTH: _____ DATE: _____

AGE: _____ GENDER: □ MALE □ FEMALE □ OTHER: _____ SSN: _____

ADDRESS: _____

PRIMARY PHONE#: _____□ CELL □ HOME OTHER PHONE#:_____□ CELL □HOME

EMPLOYER: _____ OCCUPATION: _____

EMPLOYER ADDRESS: _____ PHONE #: _____

MARITAL STATUS: □ SINGLE □ MARRIED □ WIDOWED □ DIVORCED

SPOUSE NAME: _____ PHONE #: _____

REFERRAL SOURCE: □ FRIEND/RELATIVE _____ □ PROVIDER: _____

□ 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: _____

PRIMARY INSURANCE: _____SUBSCRIBER NAME:_____DOB:_____

POLICY #: _____ GROUP #: _____

SECONARY INSURANCE: _____SUBSCRIBER NAME:_____DOB:_____

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. We always request payment at the time of service. If an appointment is missed without a 24 notice, there will be a **$150.00 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, 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 CONDITIONS YOU'RE BEING TREATED FOR OR HAVE A HISTORY OF:

☐ ANXIETY	☐ DEPRESSION	☐ HYPERTENSION
☐ CANCER	☐ HEART PROBLEMS	☐ THYROID DISORDER
☐ DIABETES	☐ HIGH CHOLESTEROL	☐ PULMONARY DISEASE
☐ ARTHRITIS	☐ SLEEP APNEA	☐ KIDNEY DISEASE
☐ LIVER DISEASE	☐ STROKE/NEURO DISEASE	☐ COLD SORES
☐ BLOOD CLOTS	☐ GI PROBLEMS	☐ STOMACH PROBLEMS

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

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

DO YOU HAVE A LATEX ALLERGY? ☐ YES ☐ NO
EXPLAIN: _____
DO YOU HAVE ANY FOOD ALLERGIES? ☐ YES ☐ NO
EXPLAIN: _____
_____

REVIEW OF SYSTEMS

ARE YOU *CURRENTLY* EXPERIENCING ANY OF THE FOLLOWING SYMPTOMS?

CONSTITUTIONAL
☐ CHRONIC PAIN
☐ FATIGUE
☐ FEVER
☐ WEIGHT GAIN/LOSS

RESPIRATORY
☐ SHORTNESS OF BREATH
☐ WHEEZING
☐ COUGH

EAR/NOSE/THROAT
☐ HAY FEVER
☐ NASAL CONGESTION
☐ SINUS PROBLEM
☐ SORE THROAT

GASTROINTESTINAL
☐ CONSTIPATION
☐ DIARRHEA
☐ HEARTBURN
☐ INCONTINENCE
☐ NAUSEA
☐ VOMITING

CARDIOVASCULAR
☐ CHEST PAIN
☐ CHEST TIGHTNESS
☐ LOWER EXTREMITY EDEMA
☐ PALPITATIONS

EYES
☐ BLURRED VISION
☐ DOUBLE VISION
☐ REDNESS
☐ EYE PAIN

SKIN PROBLEMS
☐ LESION
☐ MASS
☐ MOLE CHANGES
☐ RASH

MUSKULOSKELETAL
☐ BACK PAIN
☐ JOINT PAIN
☐ JOINT REDNESS
☐ JOINT SWELLING

CONTINUED ON NEXT PAGE

MEDICATIONS

PLEASE LIST ALL MEDICATIONS AND EYE DROPS WITH DOSE AND FREQUENCY:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

ELECTIVE INJECTABLE HISTORY
☐ BOTOX, DYSPORT, XEOMIN:
DATE OF LAST TREATMENT:
_____
INJECTION LOCATION:
_____
☐ FILLERS:
DATE OF LAST TREATMENT:
_____
INJECTION LOCATION:
_____

LIST ALL MEDICATION ALLERGIES:

_____
_____
_____
_____
_____
_____
_____

NEUROLOGICAL

☐ DIZZINESS ☐ HEADACHE
☐ MEMORY LOSS ☐ NUMBNESS/WEAKNESS
☐ TREMOR ☐ UNSTABLE GAIT

PSYCHIATRIC

☐ ANXIOUS ☐ MEMORY DISTURBANCES
☐ CONFUSED ☐ NERVOUS
☐ DEPRESSED ☐ SUBSTANCE ABUSE

DO YOU HAVE ANY OTHER HEALTH CONDITIONS? ☐ YES ☐ NO
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 ☐ MACULAR DEGENERATION ☐ OTHER: _____

WHAT ARE WE SEEING YOU 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: _____