PATIENT REGISTRATION FORM	Aesthetic, Facial and Oculoplastic Surgeons 1314 E. Sonterra Blvd, Suite 5104 San Antonio, Tx 78258	eyeplastx™ oculofacial plastic & reconstructive surgery

Demographic Information

Patient Name: _____ Today's Date: _____

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

Home #: _____ Work #: _____ Cell #: _____

DOB: _____ SSN: _____ Gender: _____

Race: ☐ American Indian ☐ Asian ☐ Black (African American) ☐ Hawaiian (Pacific Islander) ☐ Hispanic ☐ White

Email: _____

Employer Name: _____ Occupation: _____

Primary Care Physician: _____ Phone #: _____

Eye Doctor: _____ Phone #: _____

Dermatologist: _____ Phone #: _____

Pharmacy (Where you would like us to call in your prescriptions)

Pharmacy _____ Phone #: _____

Location _____

How did you hear about our clinic?

☐ Advertisement ☐ Google ☐ Dr. Referral: _____ Location: _____

☐ Website ☐ Social Media ☐ Patient Referral: _____

☐ Other _____ ☐ Health Fair ☐ Friend: _____

Clinic Services

What is the nature of your visit?

Additional Services You Would Like Information On:

☐ Wrinkle/Fine Lines Reducer
☐ Check/Lips Volumizing
☐ Double Chin Reducer
☐ Cosmetic Procedures:
☐ - Face/Mid Lifts
☐ - Chin and Neck areas
☐ Laser Skin Treatments
☐ Skin Care: ZO Products
☐ Skin Care: Chemical Peels

Emergency Contact

Name _____ Phone # _____ Relationship: _____

Primary Insurance (Information Provided Must Match Insurance Card)

Name: _____ Policy # _____ Group # _____

Policyholder Name: _____ DOB: _____ SSN: _____

Secondary Insurance (Information Provided Must Match Insurance Card)

Name: _____ Policy # _____ Group # _____

Policyholder Name: _____ DOB: _____ SSN: _____

Section I: Medications

Are you taking any medications, vitamins or herbal supplements? ☐ Yes, please list below ☐ No ☐ Separate List Provided

Are you on any Pain Management? ☐ Yes, please list below ☐ No ☐ Separate List Provided

Are you taking Aspirin? ☐ Yes, please indicate: Dosage: _____ Frequency: _____ ☐ No

Medication Name	Dosage (mg/ml)	Frequency

Section II: Allergies and Sensitivities

Check Allergies that apply: ☐ Iodine ☐ Penicillin ☐ Shellfish ☐ Sulfa Reaction:_____

Are you allergic to any other food, medications or local anesthesia? ☐ Yes, please list below ☐ No

_____

_____

Section III: Specific Medical History

1. Height: _____ Weight: _____

2. Check All Those that You Have Been Diagnosed with or Still Have or ☐ NONE:

☐ Asthma
☐ Anxiety
☐ Arthritis
☐ Atrial Fibrillation
☐ Bleeding Tendency
☐ Blood Borne Pathogens
☐ Bone Marrow Transplantation
☐ BPH (Benign Prostatic Hyperplasia)
☐ COPD - Emphysema
☐ Coronary Artery Disease
☐ Cancer: Breast
☐ Cancer: Colon
☐ Cancer: Lung
☐ Cancer: Prostate
☐ Cancer: Renal
☐ Cancer: Other: _____
☐ Depression
☐ Diabetes
☐ Dialysis
☐ Emphysema
☐ End Stage Renal Disease
☐ Epilepsy/Seizures
☐ GERD (Acid reflux)
☐ Hearing Loss
☐ Heart Trouble
☐ Hepatitis
☐ HIV/AIDS
☐ High Blood Pressure
☐ Hypercholesterolemia
☐ Kidney Trouble
☐ Leukemia
☐ Liver Trouble
☐ Lymphoma
☐ Problems Scarring
☐ Psychiatric Care
☐ Radiation Treatment
☐ Seizures
☐ Stroke
☐ Thyroid Disease: _____

Other: _____

_____

Section IV : Social History

1. Do you smoke? ☐ Never ☐ Former ☐ Current
2. Do you have a health care proxy in the event you are unable to make your own medical decisions? ☐ Yes ☐ No
   - Provide: Name and Phone Number of Health Care Proxy — Name: _____ Phone: _____
3. Do you drink alcohol? ☐ No ☐ Yes
   - Men: Do you drink 5 or more drinks/day 1 or more times a year? ☐ No ☐ Yes
   - Women: Do you drink 4 or more drinks/day 1 or more times a year? ☐ No ☐ Yes

Section V: Family History

Any blood relatives diagnosed with the following?	YES	NO	Relationship to Relative
1. Cancer	☐	☐	
2. Bleeding Tendency	☐	☐	
3. Hypertension	☐	☐	
4. Heart Disease	☐	☐	

Section VI: Surgery and Anesthesia History

1. Check All Surgeries that Apply, Indicate MM/YY or ☐ NONE

☐ Appendix
☐ Bladder
☐ Breast
- ☐ Biopsy
- ☐ Lumpectomy
- ☐ Mastectomy

☐ Colon:
- ☐ Colon Cancer Resection
- ☐ Diverticulitis
- ☐ Inflam. Bowel Disease

☐ Gallbladder

☐ Heart
- ☐ Angioplasty/Stent
- ☐ Bypass
- ☐ Transplant
- ☐ Valve Replace

☐ Joint Replacement
- ☐ Hip
- ☐ Knee

☐ Kidney
- ☐ Removed
- ☐ Stone Removed
- ☐ Transplant

☐ Liver
☐ Ovaries:
- ☐ Endometriosis
- ☐ Cyst
- ☐ Ovarian Cancer
- ☐ Tubal Ligation

☐ Pancreas
☐ Prostate
- ☐ Prostate Cancer
- ☐ TURP

☐ Rectum

☐ Skin
- ☐ Basal Cell Carcinoma
- ☐ Squamous Cell Carcinoma
- ☐ Melanoma
- ☐ Other: _____

☐ Spleen
☐ Testicles
☐ Uterus
☐ Hysterectomy
- ☐ Fibroids
- ☐ Uterine Cancer
- ☐ Cervical Cancer

2. Eye Surgeries: include MM/YY:

☐ Enucleation	☐ Lf:	☐ Rt:	☐ Both:	☐ LASIK	☐ Lf:	☐ Rt:	☐ Both:
☐ Eyelid	☐ Lf:	☐ Rt:	☐ Both:	☐ Orbital Surgery	☐ Lf:	☐ Rt:	☐ Both:
☐ Cataract	☐ Lf:	☐ Rt:	☐ Both:	☐ Retina	☐ Lf:	☐ Rt:	☐ Both:
☐ Glaucoma	☐ Lf:	☐ Rt:	☐ Both:	☐ Strabismus	☐ Lf:	☐ Rt:	☐ Both:

Other Eye Surgeries (not indicated above), include MM/YY:

_____

3. Please describe if you or a blood relative has had anesthesia complications of any kind? ☐ Yes ☐ No

_____

Section VII: Individuals Whom We May Discuss Your Medical Information

Name	DOB	Relationship	Comments/Phone Number

Patient Name:		Patient DOB:	

Consent Statements

1. I, the undersigned patient or patient's legal guardian, give my informed and voluntary consent to Aesthetic, Facial and Oculoplastic Surgeons, a.k.a. Eyeplastx to take photographs and/or video of patient named above pre-operatively, intra-operatively, and post-operatively. I understand that:
   - these photographs and/or videos will be utilized to show the transformation process to the general public which includes current and prospective patients,
   - these photographs and/or videos will be used for medical and marketing purposes to include, but not limited to, medical journals, brochures, web design, and advertising,
   - no identifying information will be used, including name, date of birth, address, or phone number,
   - any and all photographs taken will remain property of Aesthetic, Facial and Oculoplastic Surgeons,
   - this authorization is completely voluntary
2. I, the undersigned patient or patient's legal guardian, consent to the use and disclosure of Private Health Information for Treatment, Payment or Healthcare Operations. I understand that as part of the patient's named above health care, Aesthetic, Facial and Oculoplastic Surgeons, a.k.a. Eyeplastx originates and maintains paper and or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand this serves as:
   - A basis for planning my care and treatment,
   - A means of communication among the health professionals who contribute to my care,
   - A source of information for applying my diagnosis and surgical information to my bill,
   - A means by which a third party payer can verify services billed were provided, and
   - A tool for routine healthcare, such as; assessing quality, and reviewing the competence of healthcare professionals.

   Should it become necessary to disclose this protected information to another entity for the above purposes, I consent to such disclosure for these permitted uses, including disclosures via fax and transcription.

3. Due to the rising administrative costs of issuing refund checks, this office has a policy for credit balances less tha $4.00. Should your account have a credit balance for $4.00 or less, your credit balance will remain on yuor account to be applied to future services. Should you desire a refund, all amounts under $4.00 will be issued in CASH from the office located at 1314 E. Sonterra Blvd, Suite 5104, San Antonio TX 78258. Please contact the business office at (210) 495-2367 at least 1 day in advance to ensure your CASH refund is ready for pick-up. A photo ID will be required.

I have reviewed and accepted each of the consent statements stated above.

_____
Signature of Patient/Patient's Legal Guardian

_____
Printed Name of Patient/Patient's Legal Guardian

_____
Date

Office Policy Statements

1. Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you, as a health service provider, not your insurance company. We cannot become involved in disputes between you and your insurance regarding "usual and customary" charges. Our involvement will be limited to supplying factual information to facilitate claim processing.
2. All charges are your responsibility whether your insurance pays or does not pay. Not all services are a covered benefit in your medical plan. Some insurance companies arbitrarily select certain services that they do not cover. It is the responsibility of the patient to understand what is covered under their plan.
3. Fees for service, along with unpaid deductibles and co-payments are due at the time of service. We accept cash, Visa, Master Card and Discover. Patient with outstanding balances must have a payment arrangement on file to be seen in clinic. Patient will incur a $35.00 fee for any checks returned for Insufficient Funds.
4. All patients will be self-pay if any of the following conditions exist:
   a. Insurance is unable to be verified
   b. Insurance shows that the patient is ineligible
   c. Coordination of insurance benefit issue exist
5. Patients should promptly notify the Business Office of any changes in insurance coverage, billing address, legal name or referring physician.
6. No Show and cancellations for appointments with less than 48 hour notice will incur a fee of $100.00. When a patient fails to show up for an appointment or cancels last minute this prevents other patients from having that time and affects the quality of care we can offer to all patients. Appointment cancellations left on voice mail will not be considered valid and the missed appointment will still be billed as a no-show. These will be charged to the credit/debit card on file.
7. Patients who No-Show two (2) or more times in a twelve (12) month period, may be dismissed from the practice thus they can be denied any future appointments.
8. Surgical Procedures cancellations require seven (7) business day advance notice, without notification they will be subject to a $500.00 cancellation fee.
9. Medical Record Fees:
   a. Medical Records: Doctor to Doctor release: No Charge
   b. Medical Records: Patient request: $25.00 for first 25 pages; $0.50 charge per additional page.
   c. Medical Records: Attorney's Legal Matters, Insurance, etc: $50.00 plus handling charges
   d. FMLA/Disability Paperwork Completion: $25.00
   e. Payment for these services is due prior to delivery/shipment.
10. I, the undersigned patient or patient's legal guardian, authorize Aesthetic, Facial and Oculoplastic Surgeons, a.k.a. Eyeplastx to keep my credit/debit card on file for charging any outstanding balance due, to include but not limited to the following: insurance co-payments, balance due after insurance coverage has been applied to my account (up to $100.00), as well as no show and cancellation appointment fees and surgical cancellation fees (as previously stated), any cosmetic fees, or fees applied to account for Insufficient Funds.
11. Any patient balance over 60 days will receive a statement and or/phone call to either collect or arrange a payment plan. For unpaid accounts over 120 days, the practice reserves the right to send to an outside collection agency.
12. I, the undersigned patient or patient's legal guardian, authorize Aesthetic, Facial and Oculoplastic Surgeons, a.k.a. Eyeplastx to release all information necessary to secure the payment of insurance benefits. I authorize the use of this signature on all my insurance submissions.

I have reviewed and accept the Office Policies as stated above.

_____	_____	_____
Signature of Patient/Patient's Legal Guardian	Printed Name of Patient/Patient's Legal Guardian	Date