

**PATIENT REGISTRATION FORM**

Aesthetic, Facial and Oculoplastic Surgeons  
1314 E. Sonterra Blvd, Suite 5104  
San Antonio, Tx 78258



**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  Cosmetic Procedures:  Laser Skin Treatments

Check/Lips Volumizing  - Face/Mid Lifts  Skin Care: ZO Products

Double Chin Reducer  - Chin and Neck areas  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:

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

Other: \_\_\_\_\_  
\_\_\_\_\_

**Section IV : Social History**

1. Do you smoke?  Yes  No
2. Have you fallen 2 or more times in past 12 months?  Yes  No
3. Have you fallen with injury in the past 12 months?  Yes  No
4. Have you received an influenza shot, this flu season: 10/22 - 3/23  Yes  No: Allergy  No: Personal Reason
5. Have you ever received a pneumonia vaccination (PPSV23)?  Yes  No
6. Do you drink alcohol?  No  < 1 Drink/Day  1-2 Drinks/Day  >2 Drinks/Day
7. Do you have children?  Yes # \_\_\_\_\_  No

**Section V: Family History**

Any blood relatives diagnosed with the following?	YES	NO	Relationship to Relative
1. Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. Bleeding Tendency	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
6. Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

**Section VI: Surgery and Anesthesia History**

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

<input type="checkbox"/> Appendix	<input type="checkbox"/> Heart	<input type="checkbox"/> Liver	<input type="checkbox"/> Skin
<input type="checkbox"/> Bladder	- <input type="checkbox"/> Angioplasty/Stent	<input type="checkbox"/> Ovaries:	- <input type="checkbox"/> Basal Cell Carcinoma
<input type="checkbox"/> Breast	- <input type="checkbox"/> Bypass	- <input type="checkbox"/> Endometriosis	- <input type="checkbox"/> Squamous Cell Carcinoma
- <input type="checkbox"/> Biopsy	- <input type="checkbox"/> Transplant	- <input type="checkbox"/> Cyst	- <input type="checkbox"/> Melanoma
- <input type="checkbox"/> Lumpectomy	- <input type="checkbox"/> Valve Replace	- <input type="checkbox"/> Ovarian Cancer	- <input type="checkbox"/> Other: _____
- <input type="checkbox"/> Mastectomy	<input type="checkbox"/> Joint Replacement	- <input type="checkbox"/> Tubal Ligation	<input type="checkbox"/> Spleen
<input type="checkbox"/> Colon:	- <input type="checkbox"/> Hip	<input type="checkbox"/> Pancreas	<input type="checkbox"/> Testicles
- <input type="checkbox"/> Colon Cancer Resection	- <input type="checkbox"/> Knee	<input type="checkbox"/> Prostate	<input type="checkbox"/> Uterus
- <input type="checkbox"/> Diverticulitis	<input type="checkbox"/> Kidney	- <input type="checkbox"/> Prostate Cancer	<input type="checkbox"/> Hysterectomy
- <input type="checkbox"/> Inflamm. Bowel Disease	- <input type="checkbox"/> Removed	- <input type="checkbox"/> TURP	- <input type="checkbox"/> Fibroids
<input type="checkbox"/> Gallbladder	- <input type="checkbox"/> Stone Removed	<input type="checkbox"/> Rectum	- <input type="checkbox"/> Uterine Cancer
	- <input type="checkbox"/> Transplant		- <input type="checkbox"/> Cervical Cancer
  
2. Eye Surgeries: include MM/YY:
 

<input type="checkbox"/> Enucleation	<input type="checkbox"/> Lf:	<input type="checkbox"/> Rt:	<input type="checkbox"/> Both:	<input type="checkbox"/> LASIK	<input type="checkbox"/> Lf:	<input type="checkbox"/> Rt:	<input type="checkbox"/> Both:
<input type="checkbox"/> Eyelid	<input type="checkbox"/> Lf:	<input type="checkbox"/> Rt:	<input type="checkbox"/> Both:	<input type="checkbox"/> Orbital Surgery	<input type="checkbox"/> Lf:	<input type="checkbox"/> Rt:	<input type="checkbox"/> Both:
<input type="checkbox"/> Cataract	<input type="checkbox"/> Lf:	<input type="checkbox"/> Rt:	<input type="checkbox"/> Both:	<input type="checkbox"/> Retina	<input type="checkbox"/> Lf:	<input type="checkbox"/> Rt:	<input type="checkbox"/> Both:
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Lf:	<input type="checkbox"/> Rt:	<input type="checkbox"/> Both:	<input type="checkbox"/> Strabismus	<input type="checkbox"/> Lf:	<input type="checkbox"/> Rt:	<input type="checkbox"/> 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:	
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**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