THE Oculoplastics CENTER

Timothy F. McDevitt, MD • Adam R. Sweeney, MD
Queen's POB I, 1380 Lusitana Street, Suite 708 • Honolulu, HI 96813
Phone: (808) 599-4755 • F**ax**: (808) 599-5397
eyelids@oculoplasticscenter.com • www.oculoplasticscenter.com

PATIENT INFORMATION

PATIENT NAME
Last First MI

DATE OF BIRTH_____ AGE _____ MALE_____ FEMALE _____ GNC _____

SOCIAL SECURITY # (MILITARY ONLY)

SPOUSE'S NAME DATE OF BIRTH

MAILING ADDRESS

CITY/STATE ZIP

PHYSICAL ADDRESS

CITY/STATE ZIP

MAILING AND PHYSICAL ADDRESS THE SAME □

BEST CONTACT NUMBER WORK NUMBER

EMAIL

REFERRED BY **PRIMARY CARE PHYSICIAN**

BILLING: Please complete the information below if the person responsible for the bill is **not the patient listed above**.

NAME
Last First MI

DATE OF BIRTH SOCIAL SECURITY # (MANDATORY)

RELATIONSHIP TO PATIENT OCCUPATION

ADDRESS

CITY/STATE ZIP

BEST CONTACT NUMBER WORK NUMBER

Please name here any person you authorize our office to speak to regarding you protected health information:

EMERGENCY INFORMATION: Person to contact in case of emergency.

NAME: **PHONE:** **RELATIONSHIP:**

Please read the following statements carefully before signing.

1. I authorize treatment of the person named above and agree to pay all fees for such treatment.
2. I hereby authorize The Oculoplastics Center to receive all benefits to which my dependents or I are entitled to under my health insurance plan(s).
3. I authorize The Oculoplastics Center, and their agents, to release any medical information acquired in the course of my examination or treatment to process my insurance claims.
4. I have read and agree to the terms listed on "Notice of Privacy Policies for The Oculplastics Center."

SIGNATURE_____ RELATIONSHIP TO PATIENT_____

DATE_____

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Medical History

Name:_____ Date: _____

Who referred you here today? _____ Reason(s) for visit: _____
Name:_____ How long has it been present? _____
Address:_____ How often does it happen: _____
Telephone: _____ What treatment(s) have you had before? _____

What medical problem are you being treated for? Who are your doctors?

Doctor:	Illness/Condition:	Phone

Have you had any surgeries in the past? Who was/were the surgeons?

Doctor:	Surgery:	Phone:

Do you have a pacemaker?_____yes_____No If "yes", what type? _____

What medications do you take? (Pills, ointments, vitamins, eye drops)

_____
_____

Do you take aspirin containing products/medications?_____yes_____No

Allergies:_____None_____Penicillin _____Sulfa _____Fluorecein_____Idoine dyes _____Shellfish

_____Latex_____Maxitrol_____Erythromycin_____Neomycin Other, Describe: _____

Type of reaction: _____

Past Medical History: Please check any problem you have had and explain. If you have not had any problems, check "no".

General (constitutional)

Yes	No	
____	____	weight loss_____
____	____	lack of energy_____
____	____	trouble sleeping_____
____	____	problems with anesthesia_____

Eyes

Yes	No	
____	____	vision loss _____
____	____	any change in vision _____
____	____	eye pain_____
____	____	dry eye_____
____	____	other_____

Ears, Nose, Mouth, Throat

Yes	No	
____	____	hearing loss _____
____	____	sinus problems _____
____	____	infections _____
____	____	other _____

Lungs (respiratory)

Yes	No	
____	____	asthma_____
____	____	bronchitis _____
____	____	shortness of breath _____
____	____	tuberculosis (TB) _____
____	____	other_____

Stomach & Intestines (gastrointestinal)

Yes	No	
____	____	ulcers _____
____	____	diverticulitis _____
____	____	constipation_____
____	____	hepatitis _____
____	____	other _____

Kidneys, Bladder, Prostate, (genitourinary)

Yes	No	
____	____	kidney infections _____
____	____	urinary infections _____
____	____	cancer _____
____	____	on dialysis (list days)_____
____	____	other _____

Heart & Blood Vessels

Yes No

_____ _____ heart attack_____
_____ _____ high blood pressure_____
how long?_____
last check?_____
_____ _____ heart murmur _____
_____ _____ irregular heart beat _____
_____ _____ mitral valve prolapsed _____
_____ _____ chest pain_____
_____ _____ circulation problems_____
_____ _____ other_____

Nervous system & Brain

Yes No

_____ _____ seizure _____
_____ _____stroke _____
_____ _____ paralysis/weakness_____
_____ _____ numbness_____
_____ _____ other_____

Mental Illness (psychiatric)

Yes No

_____ _____ depression_____
_____ _____ chemical imbalance_____
_____ _____ mania, bipolar_____
_____ _____ schizophrenia_____
_____ _____ other_____

Endocrine System

Yes No

_____ _____ diabetes _____
_____ _____ thyroid condition _____
_____ _____ other _____

Bones, Respiratory, Muscles (Musculoskeletal)

Yes No

_osteoporosis _____
_arthritis_____
_muscle pain _____
_other _____

Skin/Breast (Integumentary)

Yes No

_____ _____Keloid scarring _____
_____ _____rashes, sensitivities _____
_____ _____skin cancer _____
_____ _____ breast cancer _____
_____ _____other_____

Blood (hematoioiogic/lymphatic)

Yes No

_____ _____anemia (low blood count) _____
_____ _____excessive bleeding _____
_____ _____clotting problems _____
_____ _____ other _____

Allergic/Immunologic

Yes No

_____ _____lupus _____
_____ _____arthritis _____
_____ _____HIV _____
_____ _____other_____

Social History

What is your occupation?_____Are you still working? _____
Do you still smoke cigarettes? _____ If "yes", how may per day?_____For how many years? _____
Do you drink alcohol?_____If "yes", how much?_____For how many years? _____
Do you exercise?_____If "yes", what kind?_____How often? _____

Have you ever lived outside of Hawaii?_____If "yes", where?_____How long? _____
Past and present drug use (legal and illegal) is important for drug and anesthetic interactions. Please indicated if we need to be aware of any drug use_____yes_____no
Have you had a blood transfusion since 1977? _____

Family Medical History: Has any member of your family (father, mother, father's parents, mother's parents, brothers, sisters) had any of the following medical problems? Please check "yes" or "no" and list which member of your family (write down "mother" of "brother", etc.) had the problem in the space provided.

Yes No

_____ _____ diabetes _____
_____ _____ thyroid disease _____
_____ _____ stroke _____
_____ _____ anemia _____
_____ _____ hepatitis _____
_____ _____ cancer _____
Type _____
_____ _____ glaucoma _____

Yes No

_____ _____ tuberculosis _____
_____ _____ heart disease _____
_____ _____ high blood pressure _____
_____ _____ kidney disease _____
_____ _____ bleeding disorder _____
_____ _____ problems with anesthesia _____
_____ _____ I do not know my family history _____

Is there anything not mentioned on this form you would like your doctor to know?

_____

Signature:_____ Date: _____

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FINANCIAL POLICY

Thank you for the opportunity to serve you. We are committed to providing you with the very best care possible. The following is a statement of our financial policy that outlines patient and office financial responsibilities.

PATIENT PAYMENTS

We accept cash, checks, Visa, and MasterCard for all payments that are due on your account. Copayments are due at the time of service for all office visits. For surgery or in-office procedures that are scheduled at a later time, estimated copayments are due in full two weeks prior to the scheduled surgery or procedure date. We will provide an invoice for your review. Once your insurance company or companies have processed the claim for your office visits, you will receive a statement from our office for any applicable remaining deductibles, copayments, and the Hawaii general excise tax.

INSURANCE

Our office will file claims with your insurance company. To ensure that we have the most accurate insurance information on file, please advise our office of any changes to your insurance coverage as soon as possible. For proper billing, if you have more than one insurance policy, please provide our office with all of your insurance cards upon registration.

SELF-PAY PATIENTS

Full payment is due at the time of service. For surgery or in-office procedures that are scheduled at a later time, payment is due in full two weeks prior to the scheduled surgery or procedure date. We will provide an invoice for your review.

STATEMENTS

Regardless of any claim pending, if there is an open balance on your account, a statement may be sent to you. Any balances remaining after your insurance has made payment are due upon receipt. Please contact our office for any questions you have regarding your statement.

COLLECTIONS AND NSF CHECKS

Delinquent accounts may be forwarded to our collection agency. A collection fee of $50 may be added to the unpaid balance to recover our costs for collection. In the event litigation is necessary, you may be liable for court costs and attorney fees as well. Our bank charges us whenever a patient presents a check that does not have funds available. As a result, we may pass along the fee of $35 to your account.

SCHEDULING SURGERY

Surgery scheduling requires careful planning and coordination between our office, the surgery center, and their operating room staff, as well as the anesthesiologist. Estimated copayments are due in full two weeks prior to your scheduled surgery date. We will provide an invoice for your review. *You may receive a separate bill from the anesthesiologist or Queen's Same Day Surgery center for your surgery. Our office does not generate these, and any questions regarding these statements should be directed to the phone number on their bill.*

REFUNDS

All refunds will be processed in a timely matter after the overpayment is discovered on an account, or at the time the refund is requested. When cash or check was used to make payment, a refund will be issued in the form of a check. When a credit card was used to make payment, a refund will be issued back to *the same* card that was charged, if possible. When issuing the refund back to the same credit card is not possible, a refund will be made by check.

MEDICAL RECORDS

Your medical records are held with the strictest of confidence. If you request a copy of your records to be sent to another physician or to yourself, a written authorization is required. Only the requested records will be forwarded. When bringing in another physician's records to our office, you may want to consider keeping a copy for yourself.

FORM COMPLETION

Forms you need our office to complete may be subject to a fee, depending on complexity.

I hereby give my consent for The Oculoplastics Center to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations. With this consent, The Oculoplastics Center and staff may call my home or alternative locations (as listed on my registration form) and leave a message on voicemail or in person in reference to any items that assist the office in carrying out treatment, payment, and healthcare operations, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory and/or pertinent results. The Oculoplastics Center may mail to my home or other alternative locations (as listed on my registration form) any items that assist the office in carrying out treatment, payment, and healthcare operations, such as surgery packets and patient statements. By signing below, I acknowledge that I have read and understand the information presented above and wish to receive treatment and services from The Oculoplastics Center. I agree to be fully responsible for any and all charges for services rendered.

We welcome the opportunity to answer any questions that you may have in regards to our financial policies. It is our goal to ensure that patients have the best possible care during their visits to our office.

PRINT NAME_____ DATE OF BIRTH _____

PATIENT SIGNATURE (OR PARENT/GUARDIAN) _____

DATE_____

I have provided the patient with this document and answered any questions that he/she had in regard to what is stated above. _____

Employee Initials/Date