EYESTHETICA
THE EYELID EXPERTS

STEVEN C. DRESNER, MD
MICHAEL A. BURNSTINE, MD
DAVID B. SAMIMI, MD
CHRISTOPHER C. LO, MD

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____

Social Security #: _____-_____-_____ Date of Birth: _____/_____/_____

Gender: ❑ Male ❑ Female ❑ Decline to Answer

Preferred pronoun: _____

Home Address: _____
Street Apt # City State Zip Code

Cell Phone: (_____) _____-_____ Home Phone: (_____) _____-_____

E-Mail Address: _____

If patient is a minor, name of responsible parent: _____
If POA (power of attorney) or HCP (health care proxy), name of responsible party: _____
Relationship to patient: _____ *Please provide copies for our records.

DEMOGRAPHIC INFORMATION

Race: ❑ American Indian or Alaskan Native ❑ Black or African American ❑ Asian ❑ Indian ❑ Hispanic ❑ White ❑ Pacific Islander ❑ Multiracial ❑ Other: _____ ❑ Decline to Answer

Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Unknown / Decline to Answer

Marital Status: ❑ Single ❑ Married ❑ Decline to Answer ❑ Widowed ❑ Divorced

Preferred Language: ❑ English ❑ Spanish ❑Other: _____

Primary Care Physician: _____ Clinic Name: _____

Clinic Address: _____
Street Suite # City State Zip Code

Clinic Phone: (_____) _____-_____ Fax Number: (_____) _____-_____

Referring Physician: _____ Clinic Name: _____

Clinic Address: _____
Street Suite # City State Zip Code

Clinic Phone: (_____) _____-_____ Fax Number: (_____) _____-_____

EMPLOYMENT INFORMATION

Employer: _____ Occupation: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Home Address: _____
Street Apt # City State Zip Code

Cell Phone: (_____) _____-_____ Home Phone: (_____) _____-_____

_____ _____
Signature of Patient or Guardian Date

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INSURANCE INFORMATION

***PLEASE PROVIDE MOST RECENT INSURANCE CARDS SO WE CAN MAKE A COPY FOR OUR RECORDS**

MEDICAL INFORMATION

Reason for Visit: _____ **When did the condition start?**_____

Allergies: Any known drug allergies? ❑ No ❑ Yes Latex Allergy? ❑ No ❑ Yes
Please list all known allergies, including medication, environmental, and food: _____
_____

Medications: Are you currently taking any medications (including eye drops) or vitamins on a regular basis? ❑ No ❑ Yes

Medication	Dose	Frequency	Reason	Medication	Dose	Frequency	Reason

Pharmacy: _____ **Phone Number:** _____ **Fax:** _____

Vaccination History: *Please list dates of vaccinations.*
Flu Vaccine (Year): _____ Pneumonia Vaccine (Year): _____ Zoster Vaccine (Year): _____

Fall History (If older than 65):
Have you had any falls within the last year? ❑ No ❑ Yes. Number of falls: _____
Any falls result in injury? ❑ No ❑ Yes *If yes, please describe*: _____
Do you use a cane? ❑ No ❑ Yes Do you use a walker? ❑ No ❑ Yes

Do you have any of the following chronic conditions:

Constitutional Problems:	❑ Chronic Fever	❑ Unexpected weight change	❑ Fatigue	❑ Other: _____
Ear, Nose, or Throat Problems:	❑ Hearing Loss	❑ Sinus Problems	❑ Sore Throat	❑ Other: _____
Heart Problems:	❑ Chest Pain	❑ Irregular Heartbeat	❑ Pacemaker	❑ Other: _____
Respiratory Problems:	❑ Wheezing	❑ Shortness of Breath	❑ Coughing	❑ Other: _____
Gastrointestinal Problems:	❑ Heartburn	❑ Abdominal Pain	❑ Diarrhea	❑ Other: _____
Urinary Problems:	❑ Pain or discomfort	❑ Blood in Urine	❑ Incontinence	❑ Other: _____
Skin Problems:	❑ Rashes	❑ Excessive Dryness	❑ Eczema	❑ Other: _____
Musculoskeletal Problems:	❑ Muscle weakness	❑ Swollen Joints	❑ Joint stiffness	❑ Other: _____
Neurologic Problems:	❑ Numbness	❑ Headaches	❑ Paralysis	❑ Other: _____
Psychiatric Problems:	❑ Depression	❑ Anxiety	❑ Bipolar	❑ Other: _____
MetabolismProblems:	❑ Excessive Thirst	❑ Excessive Hunger	❑ Excessive Urination	❑ Other: _____
Hematology/Lymphatic Problems:	❑ Bleeding	❑ Tender Lymph Nodes	❑ Lymphadenopathy	❑ Other: _____

Patient Screening for Aerosol Transmissible Diseases: (Please check which of the following symptoms you currently have)
Do you have a history of tuberculosis? ❑ No ❑ Yes If yes, please explain: _____
Do you have the flu or other Aerosol Transmitted Diseases? ❑ No ❑ Yes If yes, please explain: _____

Current Height: _____ **Current Weight:** _____

_____ _____
Signature of Patient or Guardian Date

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REVIEW OF SYSTEMS

Please answer the following questions about your medical status and history:

1. Have you ever had any eye disease (e.g. glaucoma, cataract, wandering or "lazy" eye, retinal detachment)?
   ❑ No ❑ Yes If yes, what kind? _____
   _____

2. Have you ever had eye surgery? (Include cosmetic or surgery in upper and lower lids)
   ❑ No ❑ Yes If yes, please list below

Surgery	Which Eye?	Date	Reason

3. Have you ever been treated for any of the following medical conditions? *If yes, please check which*.

❑ Allergies	❑ Cancer: _____	❑ Elevated lipids	❑ Irritable Bowel Disease
❑ Angina	❑ Cardiac Arrhythmia	❑ Gallbladder Disease	❑ Osteoporosis
❑ Anxiety	❑ COPD	❑ GERD or Acid Reflux	❑ Kidney Disease
❑ Arthritis	❑ Coronary Artery Disease	❑ Headache, migraine	❑ Seizures
❑ Asthma	❑ Cholesterol (Circle: High or Low)	❑ Heart Disease	❑ Stroke
❑ Atrial fibrillation	❑ Depression	❑ Liver Problems	❑ Thyroid disease
❑ Blood clots	❑ Diabetes (Circle: Type 1 or Type 2)	❑ High Blood Pressure	❑ Other: _____

4. Have you had any other kind of surgery? ❑ No ❑ Yes If yes, please list below:

Surgery	Date	Reason	Surgery	Date	Reason

5. Do any eye diseases or medical problems run in your family (e.g. diabetes, high blood pressure, cancer, glaucoma, macular degeneration, cataracts)? ❑ No ❑ Yes

   If yes, what kind and which family member? _____

Social History

Have you ever smoked?	❑ No	❑ Yes	❑ Cigarettes ❑ Cigars	How many? _____ How often? _____	How many years? _____ Did you quit? ❑ No ❑ Yes
Do you drink alcohol?	❑ No	❑ Yes	❑ Hard Liquor ❑ Wine	❑ Beer ❑ Mixed drinks	How often? When was your last drink? _____
Do you drink caffeine?	❑ No	❑ Yes	❑ Coffee ❑ Tea	How many cups per day?	_____

_____ _____
MD Signature Date

_____ _____
Signature of Patient or Guardian Date

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NOTICE OF PRIVACY PRACTICES

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully. At ***EYESTHETICA***, we have always kept patient health information secure and confidential. A new law requires us to continue maintaining patients' privacy, to give you this notice and to follow the terms of this notice. The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care. We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company. We may use or disclose your health information for our normal healthcare operations.

We may use your information to contact you. For example, we may send a newsletter or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone. In a medical emergency, we may disclose your health information to a family member or another person responsible for your care. We may release some or all of your health information when required by law.

If this practice is sold, your information will become the property of the new doctor/owner. Except as described above, this practice will not use or disclose your health information without your prior written authorization/consent. You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request. You have the right to know of any uses or disclose we make with your health information beyond the above normal uses. As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.

You have the right to transfer copies of your health information to another practice. We will fax or mail your files for you. You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.

You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have the right to receive a copy of this notice. If we change any of the details of this notice, we will notify you of the changes in writing. If needed, you may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, D.C., 20201. You will not be retaliated against for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our office directly at (213) 234-1000.

Acknowledgment: I have read or reviewed a copy of the ***EYESTHETICA'S***, Notice of Privacy Practices. I have been advised I can request a copy and acknowledge there is a copy in the waiting room.

Signed: _____ Date: _____
Print Name: _____
Relationship to Patient: _____

AUTHORIZATION FOR MEDICAL RELEASE FORM

I, _____, authorize the Doctors and staff of Eyesthetica to speak to the following regarding:

(Check all that apply)

- ❑ All medical information; including but not limited to records pertaining to examinations, treatments, consultations, billing records, x-rays, reports, history, laboratory findings, admissions and discharge reports, treatment records, diagnosis / prognosis records, technician and Doctor's notes and any other non-medical information in my file.
- ❑ Only Billing Records
- ❑ Only Appointment Confirmations
- ❑ Only Scheduling (including surgery)
- ❑ I decline release of my medical information with the exception to my insurance carrier, if applicable.

The above medical information shall only be released to the following persons:

Family Member or Representative	Relationship	Phone Number	Authorized Until

* This Authorization is valid for one year from signed date, unless otherwise noted.

Initial:

_____ I understand that I may terminate this Medical Authorization Form. In order to do so I must notify Eyesthetica in writing regarding termination and effective date.

_____ I know that I am entitled to a copy of this agreement.

_____ I understand that I am responsible for services rendered for treatment and payments authorized by my personal representatives.

_____ If patient is a minor, I the representative authorize the medical treatment for my child by Eyesthetica.

Signed: _____ Date: _____

Print Name: _____

Relationship to Patient: _____

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SIGNATURE ON FILE

Initial:

_____Any monies payable to Steven C. Dresner, M.D., Michael A. Burnstine, M.D., David B. Samimi, M.D., Christopher C. Lo, M.D., and Christine L. Bokman, M.D., will be paid directly to them. I authorize any medical benefits payable to me to be paid directly to Steven C. Dresner, M.D., Michael A. Burnstine, M.D., David B. Samimi, M.D., Christopher C. Lo, M.D., and Christine L. Bokman, M.D.

_____I authorize the release of any medical information to my insurance carrier as requested by them. I permit a copy of this authorization to be used in place of the original.

_____Laboratory and other tests done outside this office: You are responsible for ensuring that these are done at a provider that is contracted with your insurance. Consult the Member Services Department of your insurance for assistance.

_____I hereby give permission to Doctors Steven C. Dresner, Michael A. Burnstine, David B. Samimi, Christopher C. Lo, and Christine L. Bokman to photograph, video or otherwise illustrate my clinical condition as deemed advisable for diagnostic, educational, or research purposes. I further authorize the use of such material for teaching purposes or to illustrate scientific papers, books, or lectures at any time hereafter without inspection or approval, on my part, of the finished product of specific use to which this material may be applied. It is understood that in no way will I be identified by name.

_____By initialing here, I grant permission to Eyesthetica and its employees, agents, partners and advertisers, to use my image and likeness, including but not limited to before and after photographs, clinical records, video and testimonial statements for unrestricted use in print and electronic mediums. The patient or the patient's guardian may request removal of photographs or electronic matter at any time in writing. I release Eyesthetica from all claims and liabilities arising out of Eyesthetica's use of my image and likeness.

FOR MEDICARE PATIENTS ONLY:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or it intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the healthcare provider of any other party who may be responsible for paying for my treatment (Section 1128b of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.) Regulations pertaining to Medicare assignment of benefits also apply.

_____ _____
Signature of Patient or Guardian Date

Relationship to Patient: _____

EXPLANATION OF PRACTICE POLICY: FINANCIAL POLICIES PATIENT'S RIGHTS AND RESPONSIBILITIES

PATIENTS HAVE THE RIGHT TO:

- Be treated with professionalism and respect.
- Confidentiality regarding your medical record and all other personal information. *
- Receive explanations about tests or office procedures, or answers to any questions you may have.
- Review your medical record with your health care provider and participate in decisions regarding your healthcare.
- Consent to or refuse any medical care or treatment.

ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE:

Payment is required at the time services are rendered unless other arrangements have been made. This includes applicable coinsurance, copayments and deductible for participating insurance companies. EYESTHETICA accepts cash, personal checks (in-state only), American Express Discover Card, MasterCard or Visa. There is a $25.00 service charge for returned checks.

PPO INSURANCE:

We bill participating insurance companies as a courtesy to you. You are expected to pay your coinsurance, copayments and deductible at the time of service. You are responsible for payment of all charges. If you need assistance or have questions, please contact our **Billing Department at 855-480-9931 between 8:00 a.m. and 4:30 p.m., Monday through Friday.**

MANAGED CARE INSURANCE:

If you are enrolled in a managed care insurance plan (i.e., HMO), we must be contracted with your Medical Group or have a Letter of Agreement in place prior to your visit along with an authorization. You will be billed for services received without prior authorization.

MISSED APPOINTMENTS/LATE CANCELLATIONS:

Broken appointments represent a cost to us. Other patients could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. We reserve the right to charge for missed or late-cancellation of appointments. Excessive abuse of scheduled appointments may result in discharge from our practice.

STATEMENT OF FINANCIAL RESPONSIBILITY:

I, the undersigned, have read the above and realize that all medical charges incurred by me or my dependents for services rendered by Eyesthetica physicians, are my financial responsibility. I hereby authorize assignment and payment directly to the rendering physician. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections.

_____ _____
Signature of Patient or Guardian Date

Relationship to Patient: _____