We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we will be glad to help you.

WELCOME

EYE PLASTIC ASSOCIATES, PC
Aesthetic eyelid surgery trusted by doctors
KEVIN R. SCOTT, MD

PATIENT INFORMATION

NAME *First* *Middle* *Last*

DATE OF BIRTH (MM/DD/YYYY) SEX: ☐ M ☐ F MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED

ADDRESS

CITY STATE ZIP CODE

PATIENT'S SOCIAL SECURITY # OCCUPATION EMPLOYER

HOME PHONE # MOBILE # WORK PHONE # EMAIL

PREFERRED PHARMACY PREFERRED PHARMACY PHONE

EMERGENCY CONTACT

NAME RELATIONSHIP TO PATIENT

HOME PHONE # MOBILE # WORK PHONE #

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY SUBSCRIBER'S NAME

SUBSCRIBER'S DATE OF BIRTH (MM/DD/YYYY) SUBSCRIBER'S SOCIAL SECURITY # RELATIONSHIP TO PATIENT

POLICY # GROUP # EFFECTIVE DATE (MM/DD/YYYY) COPAY

SECONDARY INSURANCE COMPANY SUBSCRIBER'S NAME

SUBSCRIBER'S DATE OF BIRTH (MM/DD/YYYY) SUBSCRIBER'S SOCIAL SECURITY # RELATIONSHIP TO PATIENT

POLICY # GROUP # EFFECTIVE DATE (MM/DD/YYYY) COPAY

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HOW DID YOU HEAR ABOUT US?

☐ DOCTOR *(details below)* ☐ FRIEND ☐ FAMILY MEMBER ☐ WEB/INTERNET ☐ PRINT AD ☐ OTHER _____

REFERRING DOCTOR INFORMATION ☐ NOT APPLICABLE

DOCTOR THAT REQUESTED YOU SEE DR. KEVIN R. SCOTT

OFFICE ADDRESS

OFFICE PHONE #

INSURANCE/MEDICARE AUTHORIZATION

- I authorize use of this form on all my insurance submissions.
- I authorize release of information to all of my insurance carriers.
- I understand I am responsible for my bill.
- I authorize my doctor to act as my agent in helping me obtain payment from my insurance carriers.
- I authorize payment directly to my doctor.
- I permit a copy of this authorization to be used in place of the original.
- I understand that all copays are due at the time of service.

NAME (please print)

MEDICARE # (if applicable)

SIGNATURE

DATE (MM/DD/YYYY)

FINANCIAL

1. We will be happy to file your insurance claim for all medical exams and surgical charges.
2. For participating insurance plans—copays, coinsurances and deductibles are payable at the time of service.
3. For all non-participating insurances—the service is payable at the time of service.
4. Cosmetic procedures are always payable on or before the day of service.
5. Insurance companies specifically do not allow us to waive fees on co-payments and deductibles.

I understand that I am financially responsible for all charges for services rendered to me. This includes the balance remaining after the payment of possible insurance benefits. I authorize the payments of medical benefits directly to Eye Plastic Associates, P.C., and I also authorize the release of any medical or other information necessary to process this claim. I accept the responsibility for any legal fees and collection agency changes that may be incurred if I fail to pay all balances due within 60 days of service. I permit a copy of this authorization to be used in place of the original.

SIGNED

DATE (MM/DD/YYYY)

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PAST MEDICAL AND FAMILY HISTORY

PATIENT'S NAME *(if not self)* Same as above ☐ DATE (MM/DD/YYYY)

Check "Yes" or "No" to indicate if you, or any of your family members, have had any of the following:

	YOURSELF	FAMILY MEMBERS		YOURSELF	FAMILY MEMBERS		YOURSELF	FAMILY MEMBERS
Blindness	☐ YES ☐ NO	☐ YES ☐ NO	Glaucoma	☐ YES ☐ NO	☐ YES ☐ NO	Bleeding Disorder(s)	☐ YES ☐ NO	☐ YES ☐ NO
Cataracts	☐ YES ☐ NO	☐ YES ☐ NO	Lazy Eye	☐ YES ☐ NO	☐ YES ☐ NO	Arthritis	☐ YES ☐ NO	☐ YES ☐ NO
Crossed Eyes	☐ YES ☐ NO	☐ YES ☐ NO	Loss of Vision	☐ YES ☐ NO	☐ YES ☐ NO	Heart Condition	☐ YES ☐ NO	☐ YES ☐ NO
Double Vision	☐ YES ☐ NO	☐ YES ☐ NO	Poor Color Vision	☐ YES ☐ NO	☐ YES ☐ NO	High Blood Pressure	☐ YES ☐ NO	☐ YES ☐ NO
Dry Eyes	☐ YES ☐ NO	☐ YES ☐ NO	Retinal Disease	☐ YES ☐ NO	☐ YES ☐ NO	Stroke	☐ YES ☐ NO	☐ YES ☐ NO
Eye Surgery	☐ YES ☐ NO	☐ YES ☐ NO	Twitching Eyelid	☐ YES ☐ NO	☐ YES ☐ NO	Thyroid Condition	☐ YES ☐ NO	☐ YES ☐ NO
Eyelid Surgery	☐ YES ☐ NO	☐ YES ☐ NO	Diabetes	☐ YES ☐ NO	☐ YES ☐ NO	Sleep Apnea	☐ YES ☐ NO	☐ YES ☐ NO

If you have had previous eyelid surgery, please describe and indicate date performed: _____

REVIEW OF SYSTEMS

Do you have any of the following problems? (If yes, please explain):

Chronic fever, unexpected weight loss/gain, fatigue	☐ YES ☐ NO	Urinary problems (e.g. pain or discomfort, blood in urine)	☐ YES ☐ NO
Ear/nose/throat problems (e.g. Hearing loss, sinus problem, sore throat)	☐ YES ☐ NO	Skin problems (e.g. rashes, excessive dryness)	☐ YES ☐ NO
Heart problems (e.g. chest pain, irregular heart beat, afib)	☐ YES ☐ NO	Musuloskeletal problems (e.g. muscle aches, joint pain, swollen joints)	☐ YES ☐ NO
Respiratory problems (e.g. shortness of breath, wheezing, sleep apnea)	☐ YES ☐ NO	Neurological problems (e.g. numbness, weakness, headaches, paralysis)	☐ YES ☐ NO
Gastrointestinal problems (e.g. heartburn, abdominal pain, diarrhea, vomiting)	☐ YES ☐ NO	Psychiatric problems (e.g. depression, anxiety)	☐ YES ☐ NO

Are you pregnant? ☐ YES ☐ NO ***If yes, please inform Dr. Scott at the time of your first visit.*** # OF CHILDREN: _____

Alcohol Use ☐ YES ☐ NO *If yes, how often?* _____ **Do you smoke?** ☐ YES ☐ NO

KEVIN R. SCOTT, M.D.

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HEALTH HISTORY

Who do you see for your general medical care?

DOCTOR'S NAME | OFFICE PHONE #

SPECIALTY *(Primary Care Physician, Pediatrician, Internist, etc.)*

ADDRESS | CITY | STATE | ZIP CODE

Who do you see for your eye care? ☐ EYE MD/OPHTHALMOLOGIST ☐ OPTOMETRIST

EYE DOCTOR'S NAME | OFFICE PHONE #

ADDRESS | CITY | STATE | ZIP CODE

DATE OF LAST EYE EXAM (MM/YYYY)

MEDICATIONS AND ALLERGIES

List MEDICATIONS you are taking, including eye drops:

☐ NONE

List your ALLERGIES to medications or other substances:

☐ NO KNOWN DRUG ALLERGIES