San Diego
Eyelid Specialists

PATIENT DEMOGRAPHICS

Last Name: _____ First Name: _____ M.I: _____

SSN: ___-___-___ DOB: ___/___/___ Age: _____ Sex: Female

Home Phone: _____ Mobile Phone: _____ **Text Notification:** No

Preferred: Home **Is it okay to leave you a detailed message over phone and/or text?** No

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

Email Address: _____ **E-mail Notification**: No

EMERGENCY CONTACT

Name:_____Relationship:_____Phone:_____

INSURANCE INFORMATION

PLEASE PROVIDE COPIES OF INSURANCE CARDS TO FRONT DESK STAFF.

Primary Insurance:_____Secondary Insurance:_____

OTHER INFORMATION

Referred by:_____Primary Care Physician:_____

Reason for appointment: _____

CONSENT FOR PHOTOGRAPHY

I hereby authorize Dr. Srinivas Iyengar and his associates to take photographs, slides and/or digital imaging appropriate to my procedure. I further authorize the use of photographs, slides, and/or imaging for professional medical purposes, while maintaining my confidentiality, deemed appropriate including but not limited to showing the photos, slides and/or imaging on all electronic media, or using the photographs, slides and/or imaging for purposes of medical publication, medical education, patient education or during lectures to medical or lay groups and for the use in examination.

☐ **ACCEPT**, I understand that I will not be entitled to any payment or other form of remuneration as a result of any use of photographs, slides and/or imaging of my procedure and/or the interview concerning that procedure.

☐ **DECLINE**, I wish for these photographs to remain in my medical record only and not to be used for any other purposes.

X _____ _____

Signature of Patient/Guardian **Date**

PRIVACY POLICY

I hereby acknowledge that I reviewed a copy of the medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current will be posted in the reception area, and that a copy of my amended Notice of Privacy Practices will be available at each appointment.

I wish to receive a copy of the privacy practices policy by ☐ print ☐ email ☐ website ☐ I do not wish to receive a copy

X _____ _____

Signature of Patient/Guardian **Date**

RELEASE OF HEALTH RECORDS

I hereby authorize San Diego Eyelid Specialists to release my health information such as medical diagnosis, treatment, prognosis, and other pertinent data and to discuss my care with the following named person(s).

Name:_____**Relationship:** _____

X _____ _____

Signature of Patient/Guardian **Date**

FINANCIAL AGREEMENT

As a service and courtesy to you, we are happy to file your insurance claims. However, please remember that your insurance contract is between you, your employer, and the insurance company. Insurance is considered a method of reimbursing the patient fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance. It is also your responsibility to notify us of any changes in your health insurance.

I authorized San Diego Eyelid Specialists, INC. to bill my insurance for services renders to me or my dependent. I understand that I am financially responsible for all charges for services provided by San Diego Eyelid Specialists, INC. whether or not they are covered or paid by my health insurance for any reason.

If insurance is not applicable or a cosmetic service is provided, you will be financially responsible for all rendered services.

X _____ _____

Signature of Patient/Guardian **Date**

MEDICAL HISTORY

PREFERRED PHARMACY: _____ Street: _____ City/State/Zip: _____

ALLERGIES

Please list any known drug, food, or environmental allergies below.

CURRENT MEDICATIONS

Please list all current medications, including over-the-counter and supplements.

OCULAR HISTORY

Do you have or have you had any of the following ocular conditions?	
Cataract Surgery	Yes
Macular Degeneration	Yes
Glaucoma	Yes
Ocular Surgery	Yes

Please list any <u>other</u> ocular surgery: _____

_____

_____

PERSONAL MEDICAL HISTORY

Do you have or have had any of the following medical conditions? **Check the boxes that apply.**					
Hypertension	☐	Kidney Disease	☐	Osteoporosis	☐
Heart Disease	☐	Hepatitis	☐	Arthritis	☐
Stroke	☐	Cancer	☐	Peptic Ulcers	☐
Diabetes	☐	Hyperthyroidism	☐	Emphysema	☐
Asthma	☐	Hypothyroidism	☐		

SOCIAL HISTORY

Smoking: No

Alcohol Consumption: No

List any <u>other</u> medical conditions not listed above: _____

_____

List any recent surgical procedures: _____

_____