Desert Eyesthetics
OCULOFACIAL PLASTIC SURGERY

DESERT EYESTHETICS PC

REGISTRATION FORM

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home #: ( ) Cell #: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Referred to clinic by (please check one box): ❑ Dr._____ _____ ❑ Insurance Plan

❑ Family ❑ Friend ❑ Close to home/work ❑ Internet ❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary Insurance:

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Desert Eyesthetics PC or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

Desert Eyesthetics
OCULOFACIAL PLASTIC SURGERY

Original Date:
Dates Revised:

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
General Health: ☐ Poor ☐ Fair ☐ Good ☐ Excellent	
Primary Care Physician:	**Date of last visit:**

REASON FOR TODAY'S VISIT:

PERSONAL HEALTH HISTORY

List any medical problems that other doctors have diagnosed

Surgeries		
Year	Reason	Hospital

Other hospitalizations		
Year	Reason	Hospital

Have you ever had a blood transfusion?	☐ Yes	☐ No
Have you ever had a MRSA infection?	☐ Yes	☐ No
Have you ever had a reaction to anesthesia?	☐ Yes	☐ No

Please turn to next page

List your prescribed drugs and over-the-counter drugs, such as vitamins, supplements and inhalers		
Name the Drug	Strength	Frequency Taken

Allergies to medications	Latex Allergy? ☐ YES ☐ NO
Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.						
Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day		
	☐ # of years	☐ Or year quit				
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?				☐ Yes	☐ No
Personal Safety	Do you live alone?				☐ Yes	☐ No
	Do you have frequent falls?				☐ Yes	☐ No
	Do you have vision or hearing loss?				☐ Yes	☐ No
	Do you have an Advance Directive and/or Living Will?				☐ Yes	☐ No

Communication Preferences:

Email address:_____

Can we email you appointment reminders? ☐ Yes ☐ No

Can we email you about promotions or services we think you may be interested in? ☐ Yes ☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother**		
	☐ M ☐ F		**Grandfather**		

MENTAL HEALTH (HISTORY OF DEPRESSION, SUBSTANCE ABUSE, TREATMENTS, ETC..)

OTHER PROBLEMS/ REVIEW OF SYMPTOMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Cancer
☐ Head/Neck	☐ Heart Stents Date:	☐ Chemotherapy
☐ Ears	☐ Heart Surgery Date:	☐ Radiation
☐ Nose	☐ Artificial Heart Valve	☐ Arthritis Type:
☐ Throat	☐ Need Antibiotics before surgery?	☐ Eyelid disease or surgery
☐ Lungs	☐ Pacemaker Date:	☐ Tear duct problems or surgery
☐ Intestinal	☐ Strokes/TIAS Date:	☐ Dry Eyes Treatments:
☐ Bladder	☐ Bleeding problems	☐ Cataract surgery ☐ Glaucoma Surgery
☐ Circulation	☐ Liver disease/hepatitis	☐ Retina Surgery ☐ Cornea Surgery
☐ Neurologic/seizures	☐ Kidney disease	☐ Thyroid Disease ☐ Radioactive Iodine
☐ Psychiatric	☐ High blood pressure	☐ Graves Disease Onset: _____
☐ Endocrine (Diabetes)	☐ Sleep Apnea	☐ Stomach ulcers

Authorization/Verification:

The above information is true to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you.

Siganture:_____Date:_____

Financial Responsibility:

I authorize my insurance benefits be paid directly to Desert Eyesthetics PC and authorize the release of any medical information necessary to process any claims. I understand that I am financially responsible for any balance (copay, deductible, coinsurance) and for all charges incurred in the event my insurance denies payment or for noncovered services.

Signature:_____Date:_____

General Consent:

I consent to be examined by the doctor. I consent to having photographs taken before, during and after treatment as required by insurance plans. I consent to the use of my photographs for educational purposes with all identifying information removed.

Signature:_____Date:_____