



PERSONAL REGISTRATION INFORMATION

PLEASE PRINT CLEARLY USING BLACK PEN
Please fill out the following information completely.

DATE: _____

PATIENT INFORMATION

NAME: _____ **AKA:** _____ **DATE OF BIRTH:** _____

SOCIAL SECURITY NUMBER: _____ **M/F:** _____ **MARITAL STATUS:** _____

ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP CODE:** _____

OCCUPATION/EMPLOYER: _____ **DRIVERS LICENSE NO.:** _____

GUARANTOR

NAME: _____ **RELATIONSHIP:** _____

SOCIAL SECURITY NUMBER: _____ **M / F:** _____ **MARITAL STATUS:** _____

ADDRESS (if different) _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

HOME PHONE: _____ **WORK PHONE:** _____ **EMPLOYER:** _____

EMERGENCY CONTACTS

NAME: _____ **PHONE #1:** _____ **PHONE #2:** _____ **RELATION:** _____

NAME: _____ **PHONE #1:** _____ **PHONE #2:** _____ **RELATION:** _____

INSURANCE

PRIMARY INSURANCE CO: _____ **PHONE NO:** _____

INSURED NAME: _____ **INSURED DOB:** _____ **SS#:** _____

PLAN TYPE: _____ **GROUP #:** _____ **INSURED ID#:** _____

INSURED DRIVERS LICENSE NO.: _____ **RELATIONSHIP TO PATIENT:** _____

SECONDARY INSURANCE CO: _____ **PHONE NO:** _____

INSURED NAME: _____ **INSURED DOB:** _____ **SS#:** _____

PLAN TYPE: _____ **GROUP #:** _____ **INSURED ID#:** _____

INSURED DRIVERS LICENSE NO.: _____ **RELATIONSHIP TO PATIENT:** _____

Thank you for selecting Plastic Eye Surgery Associates, PLLC (PESA) for your care. To prevent any confusion over financial responsibility for medical and surgical services provided, we supply you with the following information:



NAME: _____

DATE: _____

Height: _____ **Weight:** _____

MEDICAL PROBLEM LIST

Please check/circle all current and significant past medical problems and explain below.

- | | | | |
|--|--|---|---|
| <p>HEART</p> <ul style="list-style-type: none"> <input type="checkbox"/> Heart attack / heart failure <input type="checkbox"/> Irregular heart rhythm <input type="checkbox"/> Chest pain <input type="checkbox"/> High blood pressure <input type="checkbox"/> High cholesterol <input type="checkbox"/> Pacemaker <p>BREATHING</p> <ul style="list-style-type: none"> <input type="checkbox"/> Asthma <input type="checkbox"/> Trouble breathing <input type="checkbox"/> Lung infections <input type="checkbox"/> Lung disease <p>ENDOCRINE</p> <ul style="list-style-type: none"> <input type="checkbox"/> Thyroid disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Heat/cold intolerance <p>GENITOURINARY</p> <ul style="list-style-type: none"> <input type="checkbox"/> Kidney or prostate disease <input type="checkbox"/> Trouble urinating <input type="checkbox"/> Sexually transmitted disease | <p>GENERAL HEALTH</p> <ul style="list-style-type: none"> <input type="checkbox"/> Fever <input type="checkbox"/> Fatigue or low energy <input type="checkbox"/> Night sweats or chills <input type="checkbox"/> Weight gain/loss <input type="checkbox"/> Ankle swelling <p>PSYCHIATRIC</p> <ul style="list-style-type: none"> <input type="checkbox"/> Depression / mood swings <input type="checkbox"/> Anxiety <input type="checkbox"/> Confusion <input type="checkbox"/> Poor memory <input type="checkbox"/> Drug addiction <p>CANCER / BLOOD</p> <ul style="list-style-type: none"> <input type="checkbox"/> Cancer <input type="checkbox"/> Radiation treatment <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Anemia (low blood) <input type="checkbox"/> Excessive bruising <input type="checkbox"/> Swollen glands | <p>ALLERGY / IMMUNE</p> <ul style="list-style-type: none"> <input type="checkbox"/> Hay fever <input type="checkbox"/> Frequent infections <input type="checkbox"/> HIV positive <input type="checkbox"/> Autoimmune disease <p>SKIN / BREAST</p> <ul style="list-style-type: none"> <input type="checkbox"/> Skin cancers <input type="checkbox"/> Rashes <input type="checkbox"/> Breast lumps or pain <p>EAR, NOSE, THROAT</p> <ul style="list-style-type: none"> <input type="checkbox"/> Sinus problems <input type="checkbox"/> Hearing problems <input type="checkbox"/> Hoarseness <input type="checkbox"/> Frequent nose bleeds <p>NEUROLOGIC</p> <ul style="list-style-type: none"> <input type="checkbox"/> Severe or frequent headaches <input type="checkbox"/> Stroke <input type="checkbox"/> Seizures <input type="checkbox"/> Parkinson's disease <input type="checkbox"/> Paralysis | <p>GASTROINTESTINAL</p> <ul style="list-style-type: none"> <input type="checkbox"/> Reflux <input type="checkbox"/> Indigestion <input type="checkbox"/> Bloody / tar-colored stool <input type="checkbox"/> Ulcer disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> Liver disease <p>EYE</p> <ul style="list-style-type: none"> <input type="checkbox"/> Irritation, itching, burning, or pain <input type="checkbox"/> Tearing <input type="checkbox"/> Blurry vision <input type="checkbox"/> Blindness <input type="checkbox"/> Eye swelling <p>MUSCULOSKELETAL</p> <ul style="list-style-type: none"> <input type="checkbox"/> Joint pain <input type="checkbox"/> Pain when chewing <input type="checkbox"/> Muscle cramps <input type="checkbox"/> Weakness <input type="checkbox"/> Arthritis <p>OTHER</p> <p>_____</p> |
|--|--|---|---|

Please Explain Your Significant MEDICAL PROBLEMS, SURGERIES & HOSPITALIZATIONS:

Please list DISEASES that run in your FAMILY:

Do You Smoke? Y / N

Did you EVER? Y / N

How many packs / day? _____

How many years? _____

Do You Drink Alcohol? Y / N

How many drinks / day? _____

INFORMATION SHARING

NAME: _____

DATE: _____

HOW MAY WE CONTACT YOU?

HOME PHONE: _____	<input type="checkbox"/> EMERGENCY ONLY	<input type="checkbox"/> ROUTINE	<input type="checkbox"/> OK TO LEAVE DETAILED MESSAGES
WORK PHONE: _____	<input type="checkbox"/> EMERGENCY ONLY	<input type="checkbox"/> ROUTINE	<input type="checkbox"/> OK TO LEAVE DETAILED MESSAGES
CELL PHONE: _____	<input type="checkbox"/> EMERGENCY ONLY	<input type="checkbox"/> ROUTINE	<input type="checkbox"/> OK TO LEAVE DETAILED MESSAGES
EMAIL**: _____	<input type="checkbox"/> EMERGENCY ONLY	<input type="checkbox"/> ROUTINE	<input type="checkbox"/> OK TO LEAVE DETAILED MESSAGES
OTHER: _____	<input type="checkbox"/> EMERGENCY ONLY	<input type="checkbox"/> ROUTINE	<input type="checkbox"/> OK TO LEAVE DETAILED MESSAGES

****The more available you are to us, the more quickly we can provide you with important scheduling changes, visit reminders, laboratory results, peri-operative instructions, answers to your questions, etc.**

REFERRAL

Who referred you to our practice?

NAME: _____ **Contact Info :** _____ Please don't contact them

LEGAL GUARDIAN

If you have appointed a legal guardian for your health and financial issues, please tell us who that is.

Guardian's Name: _____

PHYSICIANS / HEALTH CARE PROVIDERS

We believe it is in your best interest for us to know all the health care providers involved in your care, so that we may communicate relevant information in a timely fashion. Please list below all of your regular physicians and health care providers (including complimentary health care providers such as chiropractor, naturopath, dietician, and acupuncturist) with whom you are willing for us to communicate.

PROVIDER'S NAME	SPECIALTY	TELEPHONE NUMBER

FRIENDS AND FAMILY

Your privacy is very important to us. We can not share any information (including confirming appointment date and time) with anyone, including a spouse or care-giving child (unless they are your legal guardian) without your expressed permission. Please list below all persons with whom you will allow us to fully discuss your medical issues.

INDIVIDUAL'S NAME	RELATIONSHIP	TELEPHONE NUMBER

Signature of Patient (or legal guardian): _____

PERMISSION FOR PHOTOGRAPHS

I hereby grant permission to Plastic Eye Surgery Associates, PLLC (referred hereafter as PESA) to take photographs of me and my medical or cosmetically relevant condition for any or all of the following uses:

- 1.) Facilitate telephone conversations with PESA physicians regarding my condition.
- 2.) Documentation of any changes in my situation.
- 3.) Documentation for insurance purposes of medically necessary concerns.

In addition, I understand that such photographs, or portions thereof so cropped as to aid in masking my identity, may be used for teaching or clinical research purposes in either lecture or publication format without any remuneration to me. By signing this form I release the medical practice of PESA from any future claims as well as liability arising from the use of said photographs, understanding that to protect my privacy, un-masked, full-face photographs will NOT be used in publication, unless I provide additional written consent.

Any photographs taken by PESA remain the express property of PESA as part of my medical record. Although, like the remainder of my medical record, I have legal right to obtain copies of the same upon written request in keeping with usual state and federal laws and PESA policies.

Signature of Patient (or legal representative)

Printed Name of Patient (and legal representative, if applicable)

Date