Cosmetic and Reconstructive Surgery of the Eye Region
PLASTIC EYE SURGERY ASSOCIATES, PLLC
www.plasticeyesurgery.com

JAMES R. PATRINELY, MD, FACS
CHARLES N.S. SOPARKAR, MD, PhD, FACS
3730 Kirby Drive, Suite 900, Houston, TX 77098
Tel. (713) 795-0705 Fax (713) 807-0630

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:

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NAME: _____ DATE: _____

ALLERGIES

MEDICATION NAME	TYPE OF ALLERGIC REACTION

PHARMACY

(where you most frequently fill prescriptions)

Pharmacy: _____ Pharmacy #:_____ Pharmacy Fax:_____

MEDICATIONS CURRENTLY BEING TAKEN

(include all dietary, weight loss, and vitamin supplements)

MEDICATION NAME	DOSE	REASON FOR TAKING

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NAME: _____ DATE: _____

Height: _____ Weight: _____

MEDICAL PROBLEM LIST

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

HEART
- ☐ Heart attack / heart failure
- ☐ Irregular heart rhythm
- ☐ Chest pain
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Pacemaker

BREATHING
- ☐ Asthma
- ☐ Trouble breathing
- ☐ Lung infections
- ☐ Lung disease

ENDOCRINE
- ☐ Thyroid disease
- ☐ Diabetes
- ☐ Heat/cold intolerance

GENITOURINARY
- ☐ Kidney or prostate disease
- ☐ Trouble urinating
- ☐ Sexually transmitted disease

GENERAL HEALTH
- ☐ Fever
- ☐ Fatigue or low energy
- ☐ Night sweats or chills
- ☐ Weight gain/loss
- ☐ Ankle swelling

PSYCHIATRIC
- ☐ Depression / mood swings
- ☐ Anxiety
- ☐ Confusion
- ☐ Poor memory
- ☐ Drug addiction

CANCER / BLOOD
- ☐ Cancer
- ☐ Radiation treatment
- ☐ Chemotherapy
- ☐ Anemia (low blood)
- ☐ Excessive bruising
- ☐ Swollen glands

ALLERGY / IMMUNE
- ☐ Hay fever
- ☐ Frequent infections
- ☐ HIV positive
- ☐ Autoimmune disease

SKIN / BREAST
- ☐ Skin cancers
- ☐ Rashes
- ☐ Breast lumps or pain

EAR, NOSE, THROAT
- ☐ Sinus problems
- ☐ Hearing problems
- ☐ Hoarseness
- ☐ Frequent nose bleeds

NEUROLOGIC
- ☐ Severe or frequent headaches
- ☐ Stroke
- ☐ Seizures
- ☐ Parkinson's disease
- ☐ Paralysis

GASTROINTESTINAL
- ☐ Reflux
- ☐ Indigestion
- ☐ Bloody / tar-colored stool
- ☐ Ulcer disease
- ☐ Hepatitis
- ☐ Liver disease

EYE
- ☐ Irritation, itching, burning, or pain
- ☐ Tearing
- ☐ Blurry vision
- ☐ Blindness
- ☐ Eye swelling

MUSCULOSKELETAL
- ☐ Joint pain
- ☐ Pain when chewing
- ☐ Muscle cramps
- ☐ Weakness
- ☐ Arthritis

OTHER

_____

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? _____

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INFORMATION SHARING

NAME: _____ DATE: _____

HOW MAY WE CONTACT YOU?

HOME PHONE: _____	☐ EMERGENCY ONLY	☐ ROUTINE	☐ OK TO LEAVE DETAILED MESSAGES
WORK PHONE: _____	☐ EMERGENCY ONLY	☐ ROUTINE	☐ OK TO LEAVE DETAILED MESSAGES
CELL PHONE: _____	☐ EMERGENCY ONLY	☐ ROUTINE	☐ OK TO LEAVE DETAILED MESSAGES
EMAIL:** _____	☐ EMERGENCY ONLY	☐ ROUTINE	☐ OK TO LEAVE DETAILED MESSAGES
OTHER: _____	☐ EMERGENCY ONLY	☐ ROUTINE	☐ 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): _____

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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, clinical research purposes in lectures, publication, video or internet-based 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