Oculoplastic
Associates of
West Michigan, PLC

PATIENT INFORMATION SHEET

PLEASE PRINT

How did you select our Practice: □ Dr._____, □ Friend/Relative, □Insurance Listing, □Hospital, □ Print Material (specify) _____, □Internet (specify) _____ □Other (specify) _____

PERSONAL INFORMATION

Patient's Name _____ Date of Birth _____/_____/_____
First Middle Last SS#: _____

Address _____ Sex M F

Phone # Home _____ Work _____ Cell _____ Email _____

May we contact you (please circle all that apply) Home / Work / Cell / Email Marital Status: S M Sep W D

Employer _____ Occupation _____

Spouse's Name _____ Work Phone _____Cell Phone _____

Emergency Contact _____ Phone _____ Relation to patient _____

Primary Care Physician _____
Name Address Phone

Referring Physician _____
(If other than PCP) Name Address Phone

Eye Doctor _____
(If other than referring) Name Address Phone

INSURANCE INFORMATION Please bring your insurance card(s) at the time of your appointment.

Primary Insurance _____ Phone _____ Group #_____

Subscribers Name _____ Policy # _____ Date of Birth _____

Secondary Insurance _____ Phone _____ Group #_____

Subscribers Name _____ Policy # _____ Date of Birth _____

PHARMACY OF CHOICE

1. _____
Name Address Telephone #

2 _____
Name Address Telephone #

Oculoplastic Associates of West Michigan, PLC

MEDICAL HISTORY QUESTIONNAIRE

PLEASE PRINT Today's Date: _____

Patient Name: _____ SEX: M / F Age: _____

Reason for your visit today (Please describes the details of your problem): _____

_____

_____

_____

PERSONAL MEDICAL HISTORY: Have you **ever** had any of the following conditions?

If YES, please elaborate if applicable.

Anemia	NO	YES	_____	Hepatitis	NO	YES	_____
Arthritis (other than back)	NO	YES	_____	HIV/AIDS	NO	YES	_____
Cancer	NO	YES	_____	Hypertension	NO	YES	_____
Diabetes	NO	YES	_____	Immune Disease	NO	YES	_____
Fever blisters/ Cold Sores	NO	YES	_____	Sinus disease	NO	YES	_____
Glaucoma	NO	YES	_____	Sleep Apnea	NO	YES	_____
Graves/Thyroid disease	NO	YES	_____	Transfusion	NO	YES	_____
Heart disease or stroke	NO	YES	_____	Tuberculosis	NO	YES	_____

PERSONAL OCULAR HISTORY: Have you **ever** had any of the following conditions?

If YES, please elaborate if applicable.

Cataract	NO	YES	_____	Thyroid Eye Disease	NO	YES	_____
Dry Eye	NO	YES	_____	Trauma to Eye	NO	YES	_____
Glaucoma	NO	YES	_____	Vision Loss	NO	YES	_____
Retinal Diseases	NO	YES	_____	Watery Eyes	NO	YES	_____

OPERATIONS (Include Eye Surgeries) YEAR

_____

_____

_____

_____

_____

SOCIAL HISTORY

Live Alone: NO _____ YES

Occupation: _____

Smoking: NO YES _____ Packs/day

Alcohol: NO YES _____ Drinks/day

Drugs: NO YES _____

After Surgery/Injury, do you develop: Pigmented scars, large or thickend scars? (Please circle)

ALLERGIES Please list all medication allergies: _____

_____

_____

_____

CURRENT MEDICATIONS (Include supplements and over-the-counter medications)

_____

_____

_____

_____

_____

_____

_____

REVIEW OF HEALTH SYSTEMS: Please indicate any problems you have had in the ***past six months***.

CONSTITUTIONAL:

Weight gain/loss-more than 10 lbs NO YES _____
Marked fatigue NO YES _____
Unexplained night fever/sweats NO YES _____
Migraine headaches NO YES

EARS/NOSE/MOUTH/THROAT:

Hearing loss or ringing in ears NO YES _____
Chronic sinus problems or rhinitis NO YES _____
Nose bleeds NO YES _____
Difficulty breathing through the n NO YES _____
Difficulty swallowing NO YES

CARDIOVASCULAR:

Chest pain or angina pectoris NO YES _____
Palpitation NO YES _____
Shortness of breath with walking NO YES _____
Swelling of feet or ankles NO YES

RESPIRATORY:

Chronic or frequent cough NO YES _____
Spitting up blood NO YES _____
Shortness of breath NO YES _____
Asthma or wheezing NO YES _____

GASTROINTESTINAL:

Appetite changes NO YES _____
Difficulty swallowing NO YES _____
Frequent diarrhea or constipation NO YES _____
Stomach ulcers NO YES _____

GENITOURINARY:

Blood in urine NO YES _____
Female - irregular periods NO YES _____
Male - prostate problems NO YES _____

PSYCHIATRIC:

Depression NO YES _____
Psychosis NO YES _____

INTEGUMENTARY (Skin, breast):

Rash or itching NO YES _____
Change in skin color/hair/nails NO YES _____
Varicose veins NO YES _____
Breast pain/lump/discharge NO YES _____

MUSCULOSKELETAL:

Joint stiffness or swelling NO YES _____
Weakness in muscles or joints NO YES _____
Back pain NO YES _____
Cold extremities NO YES _____

NEUROLOGICAL:

Lightheadedness or dizziness NO YES _____
Convulsions or seizures NO YES _____
Numbness or tingling sensation NO YES _____
Tremors NO YES _____
Paralysis NO YES _____
Slurred speech NO YES _____
Head injury NO YES _____

ENDOCRINE:

Glandular or hormone disease NO YES _____
Thyroid disease NO YES _____
Diabetes NO YES _____

HEMATOLOGIC/LYMPHATIC:

Slow to heal after cuts NO YES _____
Bleeding or bruising tendency NO YES _____
Phlebitis NO YES _____
Past transfusion NO YES _____
Enlarged glands NO YES _____

ALLERGIC/IMMUNOLOGIC:

Atopic disease NO YES _____
Rheumatoid pain NO YES _____
Dry eye, dry mouth NO YES _____

FAMILY MEDICAL HISTORY: (Please indicate relation)

Cancer _____ Thyroid _____
Diabetes _____ Glaucoma _____
Heart Disease _____ Macular Degneration _____
Stroke _____ Droopy Eyelids _____
Other: _____

Are you concerned abou the condition of your skin, or interested in learning more about facial aesthetics? YES / NO

Are you interested in learning more about Botox, Dermal Fillers or Latisse? YES / NO

PHYSICIAN USE ONLY: Reviewed by: _____ Date: _____

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PATIENT AGREEMENT AND AUTHORIZATION TO RELEASE INFORMATION, FINANCIAL RESPONSIBILITY AND EVALUATION

I, the undersigned, have insurance coverage and assign directly to Oculoplastic Associates of West Michigan, PLC all surgical and/or medical benefits, if any, otherwise payable to me for services rendered. I understand that I am personally responsible for all co-payments, deductibles and non-covered services, as dictated by my insurance coverage. I understand that I am personally responsible for payment of fees if authorization has not been obtained for whatever reason. I understand that authorization does not guarantee payment by insurance plans. I understand that I am personally responsible for all charges whether or not paid by insurance. I authorize Oculoplastic Associates of West Michigan, PLC to release to my insurance carrier(s) any medical information necessary to secure payment of benefits. I permit a copy of this authorization to be used in place of the original. _____

Initials

I understand that, in addition to the examination, there may be diagnostic tests (i.e., visual field test, tear duct system probe and irrigation, CT and MRI scans, labs, etc) and photographs taken as part of my evaluation. These are performed to help in the diagnosis and management of medication conditions. I understand that, as a result, there may be additional out-of-pocket costs, as dictated by my insurance coverage. _____

Initials

I understand that it is the standard of care for Dr. Kent and the Practice to take patient photographs prior to and following the initiation of most clinical treatments and/or the performance of any surgical procedure on patients of the Practice. I hereby do ____/ do not____ give my permission for the Practice to use photographs taken of my by the Practice for physician or patient education or promotional purposes. Although photographs will not contain my name or any other identifying information, I am aware that I may or may not be identified by the photos. _____

Initials

I understand that, as part of my examination, I may be dilated, which involves having drops placed in my eyes. Dilation may cause blurred vision for several hours and make bright lights more bothersome, which vary from person to person. In extremely rare cases, dilation may trigger acute angle-closure glaucoma. I understand that I am to inform the doctor if I do not wish to have my eyes dilated at the time of the examination. _____

Initials

_____ _____

Signature of Patient/Legal Guardian Date

All Medicare patients must sign a lifetime beneficiary claim authorization: I authorize that payment of authorized Medicare benefits be made either to me, or on my behalf, to Oculoplastic Associates of West Michigan, PLC for any services furnished me by Dr. Kent. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services. I understand my signature requests that payment be made, and authorizes release of information necessary to pay the claim. If other health insurance is indicated on the electronically submitted claims, my signature authorizes release of information to the insurer or agency shown. In Medicare assigned claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for deductibles, copays, and non-covered services. Co-insurance and the deductible are based on the charge determination of the Medicare carrier.

_____ _____

Signature of Patient/Legal Guardian Date

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CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

I hereby consent Oculoplastic Associates of West Michigan, PLC to the use of disclosure of my individually identifiable health information in order to carry out treatment, payment, or health care operations. I have the right to review the practice's Notice of Privacy Practices prior to signing their consent form. (Please refer to Oculoplastic Associates of West Michigan, PLC's Notices of Privacy Practices for a more complete description of such uses and disclosures). Oculoplastic Associates of West Michigan, PLC reserves for itself the right to change the terms of its Notice of Privacy Practices at any time. A revised Noticed of Privacy Practices may be obtained by forwarding a written request to Oculoplastic Associates of West Michigan, PLC, 4070 Lake Drive SE, Suite 205, Grand Rapids, Mi 49646, or by downloading an electronic version at grandrapidseyelids.com.

I hereby consent Oculoplastic Associates of West Michigan, PLC to call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment, or healthcare operations, such as appointment reminders, insurance items, and any calls pertaining to my clinical care.

I hereby consent Oculoplastic Associates of West Michigan, PLC to mail to my home or other designated location any items that assist the practice in carrying out treatment, payment, or health care operations, such as appointment reminders and patient statements.

I hereby consent Oculoplastic Associates of West Michigan, PLC to email to my home or other designated location any items that assist the practice in carrying out treatment, payment, or health care operations, such as appointment reminders and patients statements.

I have the right to request that Oculoplastic Associates of West Michigan, PLC further restrict how my individual identifiable health information is used or disclosed to carry out treatment, payment, or health care operations. However, Oculoplastic Associates of West Michigan, PLC is not required to agree to such requested restrictions. If Oculoplastic Associates of West Michigan, PLC does agree to my requested restriction(s), such restrictions are then binding.

I have the right to revoke this Consent in writing at any time, except to the extent that Oculoplastic Associates of West Michigan, PLC has already taken action in reliance upon prior consent. Oculoplastic Associates of West Michigan, PLC may decline treatment if I do not sign this Consent Form, except to the extent that Oculoplastic Associates of West Michigan, PLC is required by law to treat individuals. If I sign this Consent and then revoke the Consent, Oculoplastic Associates of West Michigan, PLC has the right to decline to provide further treatment to me as of the time of revocation.

I HAVE READ AND UNDERSTAND THIS INFORMATION AND CONSENT TO THE ABOVE STATED TERMS.

_____ _____

Patient's (or Legan Guardian's) Signature Date

_____

Print Name