Kelly R. Everman, MD

PATIENT INFORMATION

Full Name: ____

Social Security #: ________-_______-_________

Gender: ❑ Male ❑ Female

Martial Status: ❑ Single ❑ Widowed ❑ Married ❑ Divorced

Date of Birth: _______/_______/________

Home Address:____

Street Apt # City State Zip Code

Cell Phone: (________) _________-___________ Home Phone: (________) _________-__________

E-Mail Address: ____

If patient is a minor, name of responsible parent: ____________________________________

EMPLOYMENT INFORMATION

Employer: _________________________________ Occupation: _______________________________

Business Phone: (________) _________-___________ Ext. _____________

EMERGENCY CONTACT INFORMATION

Name: _______________________________________ Relationship: ____________________________

Home Address: ____

Street Apt # City State Zip Code

Cell Phone: (________) _________-___________ Home Phone: (________) _________-__________

INSURANCE INFORMATION

Primary Carrier:

Insurance Name: _________________________________

Member ID: _____________________________________

Group Number: __________________________________

Secondary Carrier:

Insurance Name: ___________________________

Member ID: _______________________________

Group Number: ____________________________

ELITE OCULOPLASTICS

Kelly R. Everman, MD

MEDICAL INFORMATION

Primary Care Physician: ______________________________ Clinic Name: __________________________

Clinic Phone: (________) _________-___________ Fax Number: (________) _________-_________

Referring Physician: __________________________________ Clinic Name: ________________________

Clinic Phone: (________) _________-___________ Fax Number: (________) _________-___________

Reason for Visit: ____

Allergies: Any known drug allergies? ❑ No ❑ Yes   Latex Allergy? ❑ No ❑ Yes

Please list all known allergies, including medication, environmental, and food:

____

Pharmacy: __________________________________

Address: ____

Street   City   State   Zip Code

Phone Number: __________________________________

Medications: Are you currently taking any medications (including eye drops) or vitamins on a regular basis?

❑ Yes   ❑ No

Medication	Dose	Frequency	Medication	Dose	Frequency

Current Height: _______________   Current Weight: _______________

Vaccination History: *Please list dates of vaccinations.*

Pneumonia Vaccine: _______________ Flu Vaccine: ______________ Zoster Vaccine: ______________

Social History:

Have you ever smoked?	❑ No ❑ Yes	❑ Cigarettes ❑ Cigars	How many? ______________ How often? ______________	How many years? _______ Did you quit? ❑ No ❑ Yes
Do you drink alcohol?	❑ No ❑ Yes	❑ Hard Liquor ❑ Wine	❑ Beer ❑ Mixed drinks	How often? ______________ When was your last drink? __________
Do you drink caffeine?	❑ No ❑ Yes	❑ Coffee ❑ Tea	How many cups per day? _____________________	

ELITE OCULOPLASTICS

Kelly R. Everman, MD

REVIEW OF SYSTEMS

Please answer the following questions about your medical status and history:

1. Have you ever had any eye disease (e.g. glaucome, cataract, wandering or lazy eye, retinal detachment) or eye surgery? (Include cosmetic or surgery in upper and lower lids)
   ❑ No ❑ Yes If yes, what kind? ____

   ____

2. Have you had any other kind of surgery? ❑ No ❑ Yes If yes, please list below:

   ____

   ____

3. Have you ever been treated for any of the following medical conditions? *If yes, please check which*.

❑ Allergies	❑ Cancer: __________________	❑ Elevated lipids	❑ Irritable Bowel Disease
❑ Angina	❑ Cardiac Arrhythmia	❑ Gallbladder Disease	❑ Osteoporosis
❑ Anxiety	❑ COPD	❑ GERD or Acid Reflux	❑ Kidney Disease
❑ Arthritis	❑ Coronary Artery Disease	❑ Headache, migraine	❑ Seizures
❑ Asthma	❑ Cholesterol (Circle: High or Low)	❑ Heart Disease	❑ Stroke
❑ Atrial fibrillation	❑ Depression	❑ Liver Problems	❑ Thyroid disease
❑ Blood clots	❑ Diabetes (Circle: Type 1 or Type 2)	❑ High Blood Pressure	❑ Other: ________________________

4. Do you have any of the following chronic conditions:

❑ Chronic Fever	❑ Unexpected weight change	❑ Fatigue
❑ Hearing Loss	❑ Sinus Problems	❑ Sore Throat
❑ Chest Pain	❑ Irregular Heartbeat	❑ Pacemaker
❑ Wheezing	❑ Shortness of Breath	❑ Coughing
❑ Heartburn	❑ Abdominal Pain	❑ Diarrhea
❑ Pain or discomfort	❑ Blood in Urine	❑ Incontinence
❑ Rashes	❑ Excessive Dryness	❑ Eczema
❑ Muscle Aches	❑ Swollen Joints	❑ Joint Pain
❑ Numbness	❑ Headaches	❑ Paralysis
❑ Depression	❑ Anxiety	❑ Bipolar
		❑ Other: ______________________________

5. Family History

Do any eye diseases or medical problems run in your family (e.g. diabetes, high blood pressure, cancer, glaucoma, macular degeneration, cataracts)?

❑ No ❑ Yes If yes, what kind and which family member?_____________________________

____ _________________________________

Signature of Patient or Guardian Date

____

MD Signature

NOTICE OF PRIVACY PRACTICES

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully. At Elite Oculoplastics, we have always kept patient health information secure and confidential. A new law requires us to continue maintaining patients' privacy, to give you this notice and to follow the terms of this notice. The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care. We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company. We may use or disclose your health information for our normal healthcare operations.

We may use your information to contact you. For example, we may send a newsletter or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone. In a medical emergency, we may disclose your health information to a family member or another person responsible for your care. We may release some or all of your health information when required by law.

If this practice is sold, your information will become the property of the new doctor/owner. Except as described above, this practice will not use or disclose your health information without your prior written authorization/consent. You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request. You have the right to know any uses or disclose we make with your health information beyond the above normal uses. As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.

You have the right to transfer copies of your health information to another practice. We will fax or mail your files for you. You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.

You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request for will be happy to include the statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have the right to receive a copy of this notice. If we change any of the details of this notice, we will notify you of the changes in writing. If needed, you may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, D.C., 20201. You will not be retaliated against for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our office directly at (615) 250 - 0885.

Acknowledgment: I have read a copy of the Elite Oculoplastics Notice of Privacy Practices.

Signed: ______________________________ Date: ________________

Print Name: ____

Relationship to Patient: ______________________________________

AUTHORIZATION FOR MEDICAL RELEASE FORM

I, ___________________________________, authorize the Doctors and staff of Elite Oculoplastics to speak to the following regarding:

(Check all that apply)

- ❑ All medical information; including but not limited to records pertaining to examinations, treatments, consultations, billing records, x-rays, reports, history, laboratory findings, admissions and discharge reports, treatment records, diagnosis / prognosis records, technician and Doctor's notes and any other non-medical information in my file.
- ❑ Only Billing Records
- ❑ Only Appointment Confirmations
- ❑ Only Scheduling (including surgery)

The above medical information shall only be released to the following persons:

Family Member or Representative:	Relationship:	Phone Number:
_____________________________	____________	_____________
_____________________________	____________	_____________
_____________________________	____________	_____________

Initial:

_________ I understand that I may terminate this Medical Authorization Form. In order to do so I must notify Elite Oculoplastics in writing regarding termination and effective date.

_________ I know that I am entitled to a copy of this agreement

_________ If patient is a minor, I the representative authorize the medical treatment for my child by Elite Oculoplastics.

_________ I understand that I am responsible for services rendered for treatment and payments authorized by my personal representatives.

Signed: ______________________________ Date: ________________

Print Name: ____

Relationship to Patient: ______________________________________

Elite Oculoplastics

Consent to Photography

****Photographs often need to be submitted to Insurance companies for approval of services****

I hereby authorize photographs to be taken for (check all that apply):

___ For Insurance Documentation, medical purposes and monitoring my condition ***only***

___ Teaching Purposes (fellow physicians)

___ Before and after photos for website and/or to show other patients procedure/surgical improvements

______________________________ ______________

Signature of Patient/Guardian Date

____

Printed Name