# MEDICAL HISTORY FORM

Name: _____ DOB:_____ Age:_____ Height:_____ Weight:_____ Date:_____

Reason for Visit: _____

MEDICAL ALLERGIES OR SENSITIVITIES

- Do you have any medication or food allergies/sensitivities? ☐ No ☐ Yes
  If so, please list:_____
- Have you ever had any reaction to latex, rubber, or elastic? ☐ No ☐ Yes
  If so, please explain: _____

MEDICATIONS AND DOSAGE (please list all prescribed, ocular, as needed medications, vitamins, and supplement(s)

☐ NONE

| | | |
|---|---|---|
| 1. _____ | 6. _____ | 11. _____ |
| 2. _____ | 7. _____ | 12. _____ |
| 3. _____ | 8 _____ | 13. _____ |
| 4. _____ | 9 _____ | 14. _____ |
| 5. _____ | 10. _____ | 15. _____ |

OCULAR HISTORY: (Please check box if you currently have or have ever had these conditions)

☐ Anophthalmia (lost an eye) ☐ Right ☐ Left
☐ Amblyopia (lazy eye) ☐ Right ☐ Left
☐ ARMD (macular degeneration) ☐ Right ☐ Left
☐ Cataracts ☐ Right ☐ Left
☐ Glaucoma ☐ Right ☐ Left
☐ Graves' thyroid eye disease ☐ Right ☐ Left
☐ Retinal detachment ☐ Right ☐ Left
☐ Strabismus (crossed eyes) ☐ Right ☐ Left
☐ **NONE**

STAFF USE ONLY:

BP: _____
Pulse: _____
OS: _____
OD: _____

MEDICAL HISTORY: (Please check box if you currently have or have ever had these conditions)

☐ Arthritis
☐ Asthma
☐ Thyroid disease
☐ Cancer Type: _____
Treatment: ☐ Chemo ☐ Radiation ☐ Surgery
☐ Angina (chest pain)
☐ Irregular heart rhythm or rapid heartbeat (atrial fib, SVT)
☐ High blood pressure (hypertension)
☐ Heart disease (coronary artery disease or heart attack)
☐ Congestive heart failure
☐ HIV
☐ Bleeding disorders
☐ Liver Disease (Hepatitis) Type_____
☐ Stomach ulcers
☐ Gastroesophageal reflux disease (GERD)
☐ Diabetes
☐ Kidney Disease
☐ Tuberculosis
☐ Lung Disease (emphysema / COPD)
☐ Requires continuous Oxygen
☐ Obstructive sleep apnea ☐ Requires CPAP
☐ Stroke or other Brain injury, Date: _____
☐ Seizures
☐ Anesthesia Complications
☐ Other _____
☐ **NONE**

Please continue on second page

# MEDICAL HISTORY FORM

FAMILY HISTORY: Please check any that apply and list family member

☐ Anesthesia complications _____
☐ Bleeding disorders _____
☐ Diabetes _____
☐ Heart disease _____
☐ High blood pressure (hypertension)_____
☐ Thyroid disease_____

SURGICAL HISTORY: (please include ALL previous surgeries, even if not listed)

☐ Cataract surgery ☐ Right ☐ Left
☐ Glaucoma surgery ☐ Right ☐ Left
☐ Cardiac pacemaker/defibrillator
When was your last check? _____
☐ Coronary artery bypass (CABG) When? _____
☐ LASIK refractive surgery
☐ Eyelid surgery
☐ Face Lift
☐ Nose surgery (rhinoplasty)
☐ Other _____
☐ NONE

SOCIAL HISTORY:

- Do you smoke? ☐ No ☐ Yes Packs per day _____ How many years? _____ ☐ Formerly When did you quit? _____
- Alcohol use? ☐ No ☐ Yes Frequency ☐ Daily ☐ Weekly ☐ Rarely
- Recreational Drug Use? ☐ No ☐ Yes Type: _____ ☐ Formerly When did you quit? _____

Preferred Pharmacy (location you would like us to send any medications prescribed)

Pharmacy Name: _____ Address: _____

Telephone: _____ City/State: _____

_____ _____

*Patient Signature* *Date*

EYELID & FACIAL PLASTIC SURGERY ASSOCIATES

MALENA AMATO MD FACS

MARIE SOMOGYI MD FACS

**Authorization for Release of Information**

Often, when scheduling surgery, an update of your medical status is needed from your current primary care physician and/or other specialists. Please provide the following information as it pertains to your care:

**Records Requested:**

_____ Complete Medical Records

_____ Records from _____ to _____

_____ Other (Please Specify) _____

**Reason for Release:**

_____ Consultation with Another Physician

_____ Pre-Operative Planning/Scheduling

**Records Requested FROM:**

**Primary Care Physician**

Physician/Practice Name: _____ Address: _____

City/State: _____ Telephone: _____

**Cardiologist (if applicable)**

Physician/Practice Name: _____ Address: _____

City/State: _____ Telephone: _____

**Other Specialist (if applicable)**

Physician/Practice Name: _____ Address: _____

City/State: _____ Telephone: _____

**Send Records TO:**

**Eyelid & Facial Plastic Surgery Associates**

12201 Renfert Way, Suite 100

Austin, TX 78758

Fax: 512-693-2252

I understand that a reasonable amount of time (not to exceed 30 days) may be required to move my records. If possible, please send by: _____. I, the undersigned, do hereby authorize the release of information described above from my medical records. I understand that reports may include information on drug/alcohol, psychological or communicable disease treatment. I understand that I may revoke this consent in writing at any time except to the extent that action has already been taken in reliance on it. A photocopy of this consent shall be considered valid. This authorization expires automatically in one year.

Patient's Full Name: (Please Print) _____

Date of Birth: _____Social Security #: _____ Year Last Seen: _____

Any other names under which your records may be filed: _____

Patient's Signature: _____ Date: _____

(Patient or person legally authorized to consent on patient's behalf and relationship to patient)

EYELID & FACIAL PLASTIC SURGERY ASSOCIATES

MALENA AMATO MD FACS

MARIE SOMOGYI MD FACS

**Patient Information:**

Name:(Last)_____(First) _____(MI)_____

☐Male ☐Female Date of Birth: _____/_____/_____ Social Security: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: Cell: _____ Home: _____

Email: _____ May we email you if unable to contact by phone? ☐Yes ☐No

**Race (please check one):** ☐ American Indian or Alaska Native ☐Native Hawaiian or other Pacific Islander ☐ Asian

☐ White (Caucasian) ☐ Black or African American ☐ Hispanic ☐ Prefer not to disclose

**Ethnicity (please check one):** ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Prefer not to disclose

How did you hear about us? _____

Emergency Contact: _____ Phone: _____ Relationship: _____

May we release medical information to the above Contact? ☐ Yes ☐ No

**Primary Insurance Company:** _____ Phone: _____

Policy ID: _____ Group Number: _____

Policy Holder Name: _____Date of Birth: _____/_____/_____Relationship to Patient:_____

**Secondary Insurance Company:** _____ Phone: _____

Policy ID: _____ Group Number: _____

Policy Holder Name: _____Date of Birth: _____/_____/_____Relationship to Patient:_____

**RELEASE & ASSIGNMENT OF BENEFITS**: I hereby authorize the release of any and all medical information to my insurance carrier(s) or it's/their representative, for purposes necessary in the adjudication or processing of any and all insurance claims filed on my behalf and for which I am financially responsible. I further authorize all insurance benefits be paid to the provider rendering services on behalf of Malena Amato, M.D. or Eyelid and Facial Plastic Surgery Associates. **CONSENT TO TREAT**: I hereby consent to treatment by my physician to include examination and treatment, prescribing medication and procedure preparations. **ACKNOWLEDGEMENT OF RECEIPTS OF NOTICE OF PRIVACY PRACTICES**: I have been given the opportunity to read a copy of this office's Notice of Privacy Practices. I also understand that I have a right to request a copy of the Notice of Privacy Practices for my records. **CONSENT TO ACCESS RX HISTORY**: I voluntarily consent to provide Eyelid and Facial Plastic Surgery Associates access to and use of my prescription medication history from other healthcare providers or third-party pharmacy benefit payors for treatment purposes.

_____ _____

Patient's Signature (Parent if Patient is a minor child) Date

EYELID & FACIAL PLASTIC SURGERY ASSOCIATES

MALENA AMATO MD FACS
MARIE SOMOGYI MD FACS

**Patient Financial Policy**

We are pleased you have chosen our practice and are committed to the success of your medical/cosmetic treatment and care. Please initial each of the following regarding your financial responsibility:

1. _____ **METHODS OF PAYMENT ACCEPTED:**

   Cash, Cashier's Check, ACH, or Venmo @eyelidfpsa

   Credit Cards: Visa, MasterCard, Discover, American Express are accepted. ***Collective Credit Card/Debit Card payments $500 or more will have an additional 4% service charge.***

2. _____ If we participate with your managed care plan or you have a commercial insurance plan under which you are covered, we will bill your insurance(s) for all charges for services rendered. You will be responsible at the time of service for the payment of:
   - Co-Payments
   - Annual Deductible
   - Charges for non-covered or cosmetic services

3. _____ If you have no health insurance, payment is expected in full at the time of service.

4. _____ In the event we receive a returned check due to insufficient funds, a fee of $35.00 will be charged to your account and payment is due upon receipt of your statement.

5. _____ We request that you give 24-hour notice if you are unable to keep your appointment. Failure to give 24-hour notice will result in a $35.00 missed appointment fee. This fee is not covered by your insurance company.

6. _____ Cosmetic Surgery Consultation fees are $250. This fee is due at the time of scheduling your consultation in advance of your appointment.

Your signature below signifies that you understand our financial policy and your responsibility regarding charges incurred in our office.

_____ _____

Patient/Guardian Signature Date

Effective 1/1/2023

EYELID & FACIAL PLASTIC SURGERY ASSOCIATES

MALENA AMATO MD FACS
MARIE SOMOGYI MD FACS

**Photographic Release and Current Physicians**

Patient: _____ DOB: _____

I authorize Eyelid and Facial Plastic Surgery Associates to take pre-, intra-, and post- operative photos during the course of my evaluation and treatment.

I understand that the photos may be stored on electronic or paper medical records. As able, patient identifying features are excluded.

I approve the photos to be used for the following purposes:

| | | |
|---|---|---|
| Yes | No | Clinical Documentation/Insurance Authorization |
| Yes | No | Educational activities directed at patients and other physicians |
| Yes | No | Presentations to medical and non-medical organizations |
| Yes | No | Publication in medical journals |
| Yes | No | Marketing purposes such as brochures, educational pamphlets, and website |

I understand my clinical care will not be affected by my choice to authorize or not authorize use of photographs for the above stated purpose.

I hereby release and hold harmless the authorized parties of and from any and all claims, demands, damagers or causes of action in connection with the use of the photographs I have hereby authorized.

_____ _____

Patient Signature Date