OPHTHALMIC PLASTIC SURGEONS OF TEXAS

Audrey Ahuero, MD, FACS - Marc Longo, MD, FACS

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. Name:___________________________________ Sex: ❑ Male ❑ Female

Address: ___________________________________

City: ____________________ State: __________ Zip Code: ______________

Best Phone#: ____________________ Type: ❑ Home ❑ Cell Ok to leave a message? ❑ Yes ❑ No

Other Phone#: ____________________ Type: ❑ Home ❑ Cell Ok to leave a message? ❑ Yes ❑ No

Date of Birth: ____________________ Social Security Number: ____________________

Patient's Email Address: ___________________________________

❑ Yes ❑ No *I acknowledge that I may be contacted via email or standard SMS messaging to be reminded of an appointment, to give feedback on my experience, and to receive general health reminders/information. I understand the email and standard SMS messaging are not confidential methods of communication and may be insecure.*

Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Emergency Contact Name: ___________________________________

Phone Number: ____________________ **Relationship:** ______________

Employment Status: ❑ Student ❑ Employed Full-Time ❑ Employed Part-Time ❑ Retired ❑ Not Employed

Employer Name: ___________________________________

Work Phone: ____________________ Ok to call & leave message? ❑ Yes ❑ No

Please provide a local pharmacy if possible (not mail order).

Patient's Pharmacy Name: ___________________________________

Address: ___________________________________

Phone Number: ___________________________________

Referring Doctor/Clinic: ___________________________________

Address: ____________________________ City: ______________

State: __________ Zip Code: ______________ Phone #: ______________

Race and Ethnicity Identification *(We are required to ask this by Section 4302 of the Affordable Care Act)*

Are you of Hispanic or Latino descent? Persons of Cuban, Mexican, Puerto Rican, South American, or Spanish culture or origin, regardless of race, are considered Hispanic or Latino.

❑ Yes ❑ No

Indicate your race. (Select all that apply)

❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American

❑ Hispanic/Latino ❑ Native Hawaiian/Other Pacific Islander ❑ White or Caucasian

Financial Information

Patient's Payment Details – Guarantor (Person responsible for paying the bill)

Guarantor Name (if not patient): ___________________________________

SSN: ____________________________DOB:____________________________

Relation to Patient: ___________________________________

Please bring your insurance cards to your appointment. Otherwise, please complete the information below.

Primary Insurance Company - Subscriber and Insurance Company Details

Insurance Company: ___________________________________

Primary Subscriber Name: ___________________________________

Date of Birth: ___________________________________

Member ID#: ___________________________________

Secondary Insurance Company – Subscriber and Insurance Company Details

Insurance Company: ___________________________________

Subscriber Name: ___________________________________

Date of Birth: ___________________________________

Member ID#: ___________________________________

Privacy Contact Form

Persons who are involved in your care (family, friends, other doctors, etc.) may inquire about your treatment, lab results, prescriptions, appointment dates and times, etc. Please let us know with whom we may share information and their relationship with you. (Please note: in emergency situations or other situations outlined in our Notice of Privacy Practices we may share information with others who are not specifically listed on this form.)

Please list persons with whom we may share your information and their relationship to you:

Name: ____ Relationship: __________________

Name: ____ Relationship: __________________

Name: ____ Relationship: __________________

Photographic Disclaimer and Consent

Dr. Ahuero and Dr. Longo both have teaching appointments at MD Anderson Cancer Center and/or University of Texas medical school. By signing below, I hereby authorize the use of my still photographic image for educational or informative lecture purposes by OPST, Dr. Ahuero, and/or Dr. Longo. Patient names will not be published, and photos are generally cropped to the treated areas. I am aware that my still photographic image may also be used for marketing purposes such as the company website by OPST, Dr. Ahuero, and/or Dr. Longo.

I hereby give my permission for such use without receipt of any financial consideration or compensation, and I waive any right I may have to inspect or approve the finished product that may be used in connection therewith.

I hereby release, discharge and hold harmless OPST, Dr. Ahuero, and/or Dr. Longo from any liability for the use, publishing or reproduction of my photographic likeness.

____ ____________________________

Signature of Patient or Legal Representative **Date**

Notice of Privacy Practices and Patient Consent for Use and Disclosure of Protected Health Information

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that Ophthalmic Plastic Surgeons of Texas and OPST - The Surgery Center may use or disclose my protected health information for treatment, payment or health care operations—which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Ophthalmic Plastic Surgeons of Texas and OPST - The Surgery Center has a detailed document called the *‘Notice of Privacy Practices’*. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the *‘Notice’* before signing this agreement. If I ask, Ophthalmic Plastic Surgeons of Texas and OPST - The Surgery Center will provide me with the most current *Notice of Privacy Practices*.

My signature below indicates that I have been given the chance to review such copy of the *Notice of Privacy Practices*. My signature means that I agree to allow Ophthalmic Plastic Surgeons of Texas and OPST - The Surgery Center to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Ophthalmic Plastic Surgeons of Texas and OPST - The Surgery Center has taken action relying on this consent.

____ ____________________________

Signature of Patient or Legal Representative **Date**

OPHTHALMIC PLASTIC SURGEONS OF TEXAS, P.A.
AND OPST – THE SURGERY CENTER, LLC
PAYMENT, FINANCIAL RESPONSIBILITY, DISCLAIMER AND CONSENT

Payment Policy: Payment is due at the time professional services are rendered. For your convenience all major credit cards, personal checks, and cash are accepted.

Insurance Claim Filing: We accept MEDICARE, selected PPO, POS, and COMMERCIAL insurance plans. **PLEASE BE ADVISED THERE ARE SOME CLINICAL AND SURGICAL PROCEDURES THAT YOUR INSURANCE WILL NOT COVER OR MAY PROCESS AS OUT OF NETWORK; THEREFORE, BY SIGNING THIS DOCUMENT, YOU AGREE TO BE HELD FINANCIALLY RESPONSIBLE FOR SERVICES RENDERED ON OR BEFORE THE TIME OF SURGICAL OR CLINICAL SERVICE.** The filing of your insurance claim is a courtesy to you and does not guarantee payment. The medical claim payment process can take up to forty-five days to complete, we ask for your patience while this process is taking place.

Surgical Predetermination Process: Predetermination takes place prior to surgery and requires that a letter of medical necessity, any photographs and/or testing be sent to your insurance company for review and possible approval. This process can take four to six weeks, and if surgery is approved, there is no guarantee of payment. **Should you wish to proceed with an unapproved surgical procedure, you will be asked to sign the waiver in lieu of insurance claim filing, and we will ask for payment in full. Ophthalmic Plastic Surgeons of Texas, P.A. and OPST – The Surgery Center, LLC will not refund any private pay monies collected on an unapproved surgery. You may wish to file the claim on your own and agree to accept what your insurance company PAYS YOU after the surgery has taken place.**

I understand that the doctors, billing department, and staff will make all reasonable efforts to collect payments due from any third party payors/insurance companies for approved services. In the event that the insurance company/third party payor refuses to pay for whatever reasons, I agree to be financially responsible for the remaining balance on my account.

Surgery Centers: Dr. Ahuero and Dr. Longo perform surgeries in several facilities, including our own surgery center. Please be advised that your surgery may be performed at a facility in which the doctors have a financial interest or part-ownership.

Medical/Surgical Assignment of Benefits and Release of Medical Information Agreement: I request payment of my authorized insurance benefits be made payable to Ophthalmic Plastic Surgeons of Texas, P.A. and OPST – The Surgery Center, LLC on my behalf for unpaid medical and/or surgical procedures present or future charges. I also authorize OPST, Dr. Longo, and Dr. Ahuero to release medical information and photographs to my insurance companies or agent, present or in the future, for claim purposes only.
I understand Dr. Ahuero/Dr. Longo/OPST will make all necessary attempts to protect my privacy under HIPPA law. I may also ask for a copy of the privacy policy of Dr. Ahuero/Dr. Longo/OPST.

______________________________ ______________________

Signature of Patient or Legal Representative **Date**

Health History: Although ophthalmologists primarily treat the areas around your eyes, your eyes are part of your entire body. Health problems that you may have or medications that you may be taking could have an important interrelationship with the care that you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.

Patient Name: ______________________________ **Date:** ____________________

Reason for your visit today? ______________________________

Height: ____________ **Weight:** ____________

Who is your primary care physician? (name/phone/location): ______________________________

Do you see a cardiologist? ❑ Yes ❑ No, (name/phone/location)______________________________

If yes, reason you see a cardiologist: ______________________________

Have you had the following immunizations, and if so when and where:

Pneumonia Vaccine? ❑ Yes, date/by whom:______________________________ ❑ No

Influenza Vaccine? ❑ Yes, date/by whom:______________________________ ❑ No

Fall Risk:

Have you had any Falls in the past year? ❑ Yes ❑ No

If yes, # of falls: _______ Were you injured in any of the falls? ❑ Yes ❑ No

Anesthesia History:

Have you ever had general anesthesia? ❑ Yes ❑ No

Ever had problems with anesthesia? ❑ Yes ❑ No

Have you had any negative reactions to sedation or anesthesia (nausea, hallucinations, etc.)? ❑ Yes ❑ No

Ever told you have a difficult airway? ❑ Yes ❑ No

Have you ever had surgery on your head or neck? ❑ Yes ❑ No

Have you ever had radiation to your head or neck? ❑ Yes ❑ No

Do you ever use home oxygen? ❑ Yes ❑ No

If yes, how often do you use it and why: ____________________

For Women:

Are you pregnant? ❑ Yes ❑ No Are you nursing? ❑ Yes ❑ No

Please list all MEDICATIONS you are currently taking:

Medication	Dosage	Frequency	Medication	Dosage	Frequency

Please list all VITAMINS/SUPPLEMENTS you are currently taking:

Vitamin/Supplement Name	Dosage	Frequency	Vitamin/Supplement Name	Dosage	Frequency

Are you now taking:	
Prescription blood thinners (**Coumadin, Plavix, Xarelto, Eliquis,** etc.)?	❑ Yes ❑ No
Over-the-counter supplements (Fish oil, Vitamin E, Multivitamins, etc.)?	❑ Yes ❑ No
Do you take **aspirin** on a regular basis?	❑ Yes ❑ No
Any natural product, herbal supplement, homeopathic remedy?	❑ Yes ❑ No

Do you have any of the following medical conditions?			
High Blood Pressure	❑ Yes ❑ No	Anxiety	❑ Yes ❑ No
Diabetes	❑ Yes ❑ No	Depression	❑ Yes ❑ No
High Cholesterol	❑ Yes ❑ No	Hypothyroid	❑ Yes ❑ No
Heart Disease	❑ Yes ❑ No	Hyperthyroid	❑ Yes ❑ No
Pacemaker	❑ Yes ❑ No	Cancer	❑ Yes ❑ No
Defibrillator	❑ Yes ❑ No	Specify:	
Sleep Apnea	❑ Yes ❑ No	Other:	
Reflux	❑ Yes ❑ No		

Are you allergic to or have had a reaction to:		**Type of Reaction**
Local anesthetic/numbing meds?	❑ Yes ❑ No	
Penicillin?	❑ Yes ❑ No	
Other antibiotics?	❑ Yes ❑ No	
Amoxicillin?	❑ Yes ❑ No	
Sulfa drugs?	❑ Yes ❑ No	
Valium/other tranquilizers?	❑ Yes ❑ No	
Aspirin?	❑ Yes ❑ No	
Codeine or other narcotics?	❑ Yes ❑ No	
Latex?	❑ Yes ❑ No	
Soy?	❑ Yes ❑ No	
Eggs/yolk?	❑ Yes ❑ No	
Sulfites?	❑ Yes ❑ No	
Other allergies:		

Past Surgical/Hospitalization History

Month/Year	Surgical Procedure Description	Surgeon, if known	Hospitalization Required?
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ No

Family History: Please check if your family has a history of the following conditions	Diabetes	High Blood Pressure	Heart Disease	Stroke	Cancer	Mental Illness	Other
Father: ❑ Alive ❑ Deceased Birth Year: _______ Age: _____	❑	❑	❑	❑	❑	❑	❑
Mother: ❑ Alive ❑ Deceased Birth Year: _______ Age: _____	❑	❑	❑	❑	❑	❑	❑
Other:___________ ❑ Alive ❑ Deceased Birth Year: _______ Age: _____	❑	❑	❑	❑	❑	❑	❑

Social History:

Recreational drug use? ❑ Yes ❑ No Type: ______________ Frequency: ____________

Exercise? ❑ Yes ❑ No Type: ______________ Frequency: ____________

Caffeine? ❑ Yes ❑ No Type: ___________ Amount per day: ___________

Green or herbal tea? ❑ Yes ❑ No Type: ______________ Frequency: ____________

Smoking/Tobacco Use:

1. Which of the following applies: ❑ Never Smoker ❑ Current Smoker ❑ Former Smoker ❑ Tobacco User

2. If you are a CURRENT SMOKER, please answer the following: When did you start smoking: ____________

How often do you smoke cigarettes? ❑ Every day ❑ Some days but not every day

How many cigarettes a day do you smoke? ❑ 5 or less ❑ 6-10 ❑ 11-20 ❑ 21-30 ❑ 31 or more

How soon after you wake up do you smoke your first cigarette? ❑ Within 5 min ❑ 6-30 min ❑ 31-60 min ❑ After 60 min.

Are you interested in quitting? ❑ Ready to quit ❑ Thinking about quitting ❑ Not ready to quit

3. If you are a FORMER SMOKER: When did you start smoking: ___________ When did you stop: ________________

How long has it been since you smoked? ❑ Less than 1 month ❑ 1-3 months ❑ 3-6 months ❑ 6-12 months ❑ 1-5 years ❑ 5-10 years ❑ Over 10 years

Other Tobacco? ❑ Yes ❑ No Type: ___________________________________

Alcohol Use:

1. Did you have a drink containing alcohol in the past year? ❑ Yes ❑ No

2. If "Yes": How often did you have a drink containing alcohol in the past year?

❑ Never ❑ Monthly or less ❑ 2 to 4 times a month ❑ 2 to 3 times per week ❑ 4 or more times a week

3. If "Yes": How many drinks did you have on a typical day when you were drinking in the past year?

❑ 1 or 2 ❑ 3 or 4 ❑ 5 or 6 ❑ 7 to 9 ❑ 10 or more

4. If "Yes": How often did you have six or more drinks on one occasion in the past year?

❑ Never ❑ Less than monthly ❑ Monthly ❑ Weekly ❑ Daily or Almost Daily

Review of Systems **Check if you are currently experiencing any of the following symptoms:**

Normal ❑ **1) Constitutional**
- ❑ Fever
- ❑ Weight Loss
- ❑ Other: _________

Normal ❑ **2) Eyes**
- ❑ Blurred Vision
- ❑ Double Vision
- ❑ Pain
- ❑ Discharge
- ❑ Other: _________

Normal ❑ **3) Ears, Nose, Mouth, Throat**
- ❑ Pain
- ❑ Mass
- ❑ Discharge
- ❑ Hearing Loss
- ❑ Smell
- ❑ Other: _________

Normal ❑ **4) Cardiovascular**
- ❑ Chest Pain
- ❑ Irreg. Heart Beat
- ❑ Other: _________

Normal ❑ **5) Respiratory**
- ❑ Short of Breath
- ❑ Cough
- ❑ Asthma
- ❑ Other: _________

Normal ❑ **6) Gastrointestinal**
- ❑ Bowel habits/change
- ❑ Diarrhea
- ❑ Constipation
- ❑ Ulcers
- ❑ Other: _________

Normal ❑ **7) Hematologic/Lymphatic**
- ❑ Anemia
- ❑ Blood Disease
- ❑ Free Bleeder
- ❑ Swollen Lymph Nodes
- ❑ Other: _________

Normal ❑ **8) Musculoskeletal**
- ❑ Weakness
- ❑ Joint Pain
- ❑ Decreased ROM
- ❑ Other: _________

Normal ❑ **9) Integumentary (Skin/Breast)**
- ❑ Masses/Tumors
- ❑ Pigmented Lesions
- ❑ Rash
- ❑ Other: _________

Normal ❑ **10) Neurologic**
- ❑ Weakness
- ❑ Tingling
- ❑ Numbness
- ❑ Other: _________