

PATIENT INFORMATION

Name: _____
Address: _____
City, State, Zip: _____
Email Address: _____
Home Phone: _____
Mobile Phone: _____
Work Phone: _____
Date of Birth: _____
Social Security #: _____
Marital Status: _____

PERSONAL PHYSICIANS

Referring Doctor: _____
Address: _____
City, State, Zip: _____
Phone #: _____

Eye Doctor: _____
Address: _____
City, State, Zip: _____
Phone #: _____

Medical Doctor: _____
Address: _____
City, State, Zip: _____
Phone #: _____

EMPLOYMENT INFORMATION

Your Occupation: _____
Employer: _____
Address: _____
City, State, Zip: _____
Phone #: _____

Your Spouse's occupation: _____
Employer: _____
Address: _____
City, State, Zip: _____
Phone #: _____

HEALTH INSURANCE INFORMATION

Primary Insurance: _____
Member ID #: _____
Subscriber's Name: _____
Relationship to Patient: _____
Secondary Insurance: _____
Member ID #: _____
Subscriber's Name: _____
Relationship to Patient: _____

*****Please have your cards available for copying*****

INJURY INFORMATION

Date of injury: _____
Work related injury: _____ YES NO
Worker's Comp. Company: _____
Phone number: _____
Worker's Comp. Contact: _____
Phone number: _____
Personal injury claim? _____ YES NO
Attorney's name: _____
Phone number: _____

A CONTACT PERSON IF YOU ARE UNAVAILABLE

Contact's name: _____
Relationship to patient: _____
Phone number: _____

POWER-OF-ATTORNEY

POA name: _____
Relationship to patient: _____
Phone number: _____

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS:

******All patients please read and sign below:******

All Patients: I authorize the release of any medical information necessary to process this claim. I also authorize payment of medical benefits directly to Enzer & Associates, P.C. In the event you are required to proceed with any collection proceedings, I shall be responsible for all reasonable fees associated with the collection of my debt, including but not limited to 1.5% per month interest on the outstanding balance, attorney's and/or collections fees. I agree that I will be responsible to pay Dr. Enzer for all services rendered, including those not covered, or denied for payment by my insurance company.

Medicare Patients: I request that payment of authorized Medicare benefits be made either to me or on my behalf to Enzer & Associates, P.C. for any services furnished me by that physician. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

Signature: _____ Date: _____

MEDICAL HISTORY QUESTIONNAIRE –PAGE 1

Name: _____

Date: _____

(Use next page to elaborate any 'YES' answers)

PERSONAL AND FAMILY MEDICAL HISTORY

Check if you or a family member have ever been treated for:

	<u>You</u>	<u>Family</u>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack / Irregular beats	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema / Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Poor Clotting / Bruise easily	<input type="checkbox"/>	<input type="checkbox"/>
Poor Circulation	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Eye Problems	<input type="checkbox"/>	<input type="checkbox"/>
Other Significant Condition	<input type="checkbox"/>	<input type="checkbox"/>

(Please elaborate above condition here)

HAVE YOU BEEN DIAGNOSED WITH:

Hepatitis Yes No

HIV Yes No

MRSA (methicillin resistant
Staphylococcus aureus) Yes No
If so, when? _____

Have you been in the hospital or any other overnight institu-
tion in the last six months? Yes No
If so, when? _____

Sleep apnea? Yes No

Do you use a machine to breathe at night?
 Yes No

MEDICATIONS

List all of your current prescription medications (including
dosages (use next page if necessary):

List all of your herbal and over-the-counter medications
(including dosages (use next page if necessary):

Do you take Aspirin? Yes No

Do you take non-steroidal anti-inflammatory medication (Advil,
Aleve, Motrin, ibuprofen, etc.)? Yes No

ALLERGIES

Have you, or a family member ever had a reaction to
anesthesia? Yes. No.

Are you allergic to any medications? Yes No

(If you answered yes, please give the name of the medication
and the reaction):

This page was reviewed by Dr. Yoash Enzer

Signature: _____ Date: _____

MEDICAL HISTORY QUESTIONNAIRE - PAGE 2

Name: _____

Date: _____

SOCIAL HISTORY

Do you smoke now? Yes. No.

If yes, Quantity smoked per day: _____.

Smoked a total of _____ years.

Average weekly / monthly alcoholic beverage consumption? _____

OCULOPLASTIC REVIEW OF SYSTEMS

Place a check if you have any of the following problems:

- | | |
|--|--|
| <input type="checkbox"/> Dry eyes | <input type="checkbox"/> Lid / Face Spasms |
| <input type="checkbox"/> Foreign body sensation | <input type="checkbox"/> Facial pain / numbness |
| <input type="checkbox"/> Red eyes | <input type="checkbox"/> Facial weakness / palsy |
| <input type="checkbox"/> Itchy eyes | <input type="checkbox"/> Eye, eyelid, or facial injury |
| <input type="checkbox"/> Sticking / crusted lashes | <input type="checkbox"/> Decreased / poor vision |
| <input type="checkbox"/> Stye or chalazion | <input type="checkbox"/> Loss of vision |
| <input type="checkbox"/> Pus around the eye | <input type="checkbox"/> Double vision |
| <input type="checkbox"/> Wet eyes | <input type="checkbox"/> Double vision |
| <input type="checkbox"/> Eye(s) that bulge / sink | <input type="checkbox"/> Eye that turns in / out |
| <input type="checkbox"/> Eye pressure | <input type="checkbox"/> Runny nose |
| <input type="checkbox"/> Drooping eyelid | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Eyelid retraction | <input type="checkbox"/> Eye / lid / facial surgery |
| <input type="checkbox"/> Thyroid eye disease | <input type="checkbox"/> Other? |
| <input type="checkbox"/> Eyelid growth | |

SYSTEMIC REVIEW OF SYSTEMS

Place a check if you have any problems in the following areas, and give details on the back of the page:

- Constitutional (recent change in weight, energy level, temperature, etc.)
- Neurologic (brain, spinal cord, etc.)
- Head, ears, nose, throat, and sinuses
- Dermatologic (skin, hair, nails)
- Heart / Circulation (including blood vessels)
- Respiratory (lungs and breathing passages)
- Gastrointestinal (stomach, intestines, rectum)
- Genitourinary (genitals, kidneys, bladder, prostate)
- Hematologic (blood, clotting, and lymph glands)
- Endocrine (thyroid, diabetes, pancreas, etc)
- Rheumatologic (joints, autoimmune conditions)
- Allergy
- Psychiatric

SURGICAL HISTORY

List all surgeries and their dates (use back of page if necessary):

ADDITIONAL INFORMATION SPACE:

This page was reviewed by Dr. Yoash Enzer

Signature: _____ Date: _____

PATIENT PHOTOGRAPHY CONSENT

I, _____ hereby give my permission to Enzer & Associates, P.C. (i.e. Dr. Enzer or his associates) to photograph me for ***diagnostic purposes and for medical records***. I authorize the use of the photographs for teaching purposes or to illustrate scientific papers or medical books at any time hereafter without inspection or approval on my part, of the finished product or specific use to which these photographs may be applied. I hereby consent to any or all of the above.

SIGNATURE OF PATIENT

DATED SIGNED

Please note:

As part of your examination, Enzer & Associates, P. C. (i.e. Dr. Enzer or his associates) routinely take photographs for *diagnostic purposes that also serve as part of your medical record and documentation for your insurance company.*

Being actively involved in medical education and research publication, it is occasionally necessary to use "real life" cases as examples. The name of the patient is never disclosed and in most circumstances the photographs are extreme close-ups of the eye area, not full face views.

YOASH R. ENZER, MD, FACS

Enzer & Associates, PC

Ophthalmic Plastic and Reconstructive Surgery

Orbital and Lacrimal Surgery

Cosmetic Surgery

Southside Medical Center

120 Dudley Street, Suite #104

Providence, RI 02905

401-274-4464

APPOINTMENT POLICY

EFFECTIVE OCTOBER 1, 2006, our appointment policy for all patients will change. Unlike many doctor offices, we do not overbook our patients. We work very hard to arrange our schedule such that our patients do not wait unreasonable periods of time. These reserved time slots are booked especially for you, our valued patients. As a courtesy, we make every effort to give our patients a reminder call several days in advance. Unfortunately, there have been too many instances where the doctor or his staff waits for patients who do not adhere to our current 24-hour cancellation policy, simply not showing up. The lack of a courtesy call is also unjust to our many patients who have to wait weeks or months for an appointment. Additionally, leaving a message with our answering service the night before a scheduled appointment *does not* constitute a 24-hour notice. Therefore, we feel an improvement is necessary.

The following fees will be charged for all missed appointments, not cancelled 24-hours prior to your scheduled time with either Dr. Enzer, our nurse, or our estheticians:

Dr. Enzer: 15 minute appointment = \$ 50.00
 30 minute appointment = \$100.00
 45 minute appointment = \$150.00

Registered Nurse: 30 minute appointment = \$ 50.00

Estheticians: One half of treatment cost

You may either put this charge on a credit card, or should you wished to be billed, there will be an additional \$25.00 fee from our billing company. This must be paid in full before booking another appointment.

As always, we strive to provide the best care to our patients, and thank you for your understanding in this matter.

Patient's Name (Printed)

Date of Signature

Patient's Signature

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have had the opportunity to read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I also reserve the right how I want to be contacted:

- I give permission for your office to contact me by phone or by mail as listed on my patient information sheet.
- Dr Enzer should contact me as follows: _____
- Dr. Enzer’s office should not make any attempt to contact me. I assume full financial responsibility for any and all missed appointments.

Patient’s Name (or if Minor: Parent/Guardian)

Patient (or Representative) Signature

Date of Signature

OFFICE USE ONLY

I attempted to obtain the patient’s signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Reason:	Initials:
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