J. Justin Older
Eyelid Institute
PATIENT INFORMATION

TODAY'S DATE _____/_____/_______ DATE OF BIRTH _____/_____/_____ AGE _____ SEX ( ) M ( ) F

NAME *(First M. Last)* ________________________________ SOCIAL SECURITY # ______-_____-________

ADDRESS ________________________ ________________ __________ __________
STREET CITY STATE ZIP

HOME PHONE (_____) ________________ CELL PHONE (____) ______________ OTHER (____) ______________
E-MAIL ________________________________ MARITAL STATUS ( ) SINGLE ( ) MARRIED ( ) DIVORCED ( ) WIDOWED

MAY CONFIDENTIAL MESSAGES BE LEFT ON THE NUMBER PROVIDED? ( ) YES ( ) NO PREFERRED LANGUAGE ________________

RACE ( ) CAUCASIAN ( ) AFRICAN AMERICAN ( ) ASIAN ( ) OTHER ETHNICITY ( ) HISPANIC OR LATINO ( ) NON HISPANIC OR LATINO

EMERGENCY CONTACT NAME ________________________ PHONE (____) ________________________

EMPLOYER ____________________ EMPLOYER'S PHONE (___) ______________ OCCUPATION ______________

PRIMARY CARE DR ________________________________ **PHONE** (____) ____________________

REFERRING DR ________________________________ **PHONE** (____) ____________________

PHARMACY & LOCATION ____________________________ **PHONE** (____) ____________________

HOW DID YOU HEAR ABOUT DR. OLDER (IF NOT DR. REFERRED) ________________________________

INSURANCE COMPANY NAME ______________________ POLICY HOLDER NAME ____________________ D.O.B. ________

POLICY/MEMBER ID ____________________ GROUP # ____________ EFFECTIVE DATE ____________ MEMBER SS# ____________

SECONDARY INSURANCE

INSURANCE COMPANY NAME ______________________ POLICY HOLDER NAME ____________________ D.O.B. ________

POLICY/MEMBER ID ____________________ GROUP # ____________ EFFECTIVE DATE ____________ MEMBER SS# ____________

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I, or my dependent, have insurance coverage with the insurance company(ies) listed above and assign directly to J. JUSTIN OLDER EYELID INSTITUTE all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

RESPONSIBLE PARTY SIGNATURE: ____ **DATE** ______________

PRIVACY PRACTICES AND RIGHTS

I acknowledge that I have received and/or read and have been offered a copy of the office's NOTICE OF PRIVACY AND PRACTICES AND RIGHTS. I have read the notice and I understand my privacy rights and the office's privacy policies.

PATIENT SIGNATURE ____ **DATE** ______________

REFUSAL TO SIGN I acknowledge that I have read and have been offered a copy of the office's NOTICE OF PRIVACY PRACTICES & RIGHTS and refuse to sign.

PATIENT SIGNATURE ____ **DATE** ______________

PHOTOGRAPHY

I consent to being photographed as necessary to document my condition, treatment and outcome. I understand these photographs may be submitted to my insurance company as required for determination of payment. They may also be used in medical education, publication, and/or research as deemed necessary by Dr. Older. I authorize this use with the agreement that my personal information will only be used as required for insurance and billing purposes or as required by law.

PATIENT SIGNATURE ____ **DATE** ______________

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PATIENT NAME: ______________________________ **DATE:** __________

MEDICAL HISTORY:

What is the reason for your appointment today? ______________________________

How long have you had this problem? ______________________________

Are you currently, or have you ever, been treated for any eye disease? ☐ No ☐ Yes (Please describe):

____

Have you ever worn contacts? NO YES *(gas perm/hard/soft and length of time)* __________

DO YOU HAVE ANY OF THE FOLLOWING:			*(if yes, explain)*
Fever, chills, night sweats, unexplained fatigue or weight loss	NO	YES	__________
Thyroid disease *(overactive/underactive, nodules, cancer)*	NO	YES	__________
Ear, nose or throat problems	NO	YES	__________
Heart or vascular problems *(high blood pressure, heart attack, congestive heart failure, irregular heartbeat, shortness of breath, pacemaker, valve, stent)*	NO	YES	__________
Breathing/Lung problems *(asthma, chronic cough, emphysema, COPD, tuberculosis)*	NO	YES	__________
Gastrointestinal problems *(gastritis, colitis, hepatitis (type___)*	NO	YES	__________
Genitourinary, kidney, bladder, prostate problems	NO	YES	__________
Skin, nail, hair problems *(rosacea, dermatitis, psoriasis, skin cancer)*	NO	YES	__________
Nervous System *(TIA, stroke, palsy, tremor, seizures, headaches, depression, anxiety, memory loss)*	NO	YES	__________
Blood Disorder *(anemia, blood clots, easily bruised, difficulty clotting)*	NO	YES	__________
Diabetes *(type I, type II; diet controlled, oral medicine, insulin)*	NO	YES	__________
HIV or AIDS	NO	YES	__________
Cancer *(type, method of treatment)*	NO	YES	__________
Women Only: Could you be pregnant?	NO	YES	__________

OTHER HEALTH PROBLEMS OR CONCERNS NOT LISTED: ______________________________

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PATIENT NAME:______________________________ **DATE:**______________

SURGERIES: **MONTH/YEAR**
(Please list all major surgeries, *(i.e. hip or knee replacement)* as well as any eye, eyelid, facial or cosmetic procedures):

______________________________ ______________
______________________________ ______________
______________________________ ______________
______________________________ ______________
______________________________ ______________

Any problems with anesthesia? ☐ No ☐ Yes (Please describe) ______________________

ALLERGIES: *(medications, foods,* ***LATEX****, tape, etc)*

	reaction:		reaction:
______	______	______	______
______	______	______	______
______	______	______	______

MEDICATIONS: *(Include all over-the-counter medications, herbs, vitamins and eye drops/ointment)*	**DOSE**	**FREQUENCY**

FAMILY HISTORY: Do any BLOOD family members have: *(if yes, who?)*

Droopy eyelids	NO YES ______	Thyroid disease	NO YES ______
Neuromuscular disorders	NO YES ______	Cancer of the eye or eyelids	NO YES ______

SOCIAL HISTORY:

Do you use tobacco? *(cigar, cigarettes, e-cigarettes, chewing tobacco)* NO YES FORMER *(quit ______)*

Do you drink alcohol? NO YES *(daily, socially, rarely, never)*