OCULOPLASTIC SURGEONS of OKLAHOMA

ERIN L. HOLLOMAN, M.D. | ADAM G. DE LA GARZA, M.D. | DIANA A. TAMBOLI, M.D. | STERLING S. BAKER, M.D.

WELCOME TO OUR CLINIC!

Placing your trust in our physicians and staff is a very big decision and we would like to say thank you for choosing us. We would like to make sure that everything goes smoothly for you during each of your visits, so please ask us if you have any questions, comments or need further information or clarification on any products or services.

For your convenience, we have attached all forms that you will need to complete prior to your visit. We are dedicated to patient care, education and satisfaction. We are looking forward to meeting you!

THANK YOU AGAIN FOR PLACING YOUR TRUST WITH US.

Sincerely,

Staff of the Oculoplastic Surgeons of Oklahoma

DR. HOLLOMAN | DR. DE LA GARZA | DR. TAMBOLI | DR. BAKER

16315 N. MAY AVENUE, EDMOND, OK 73013

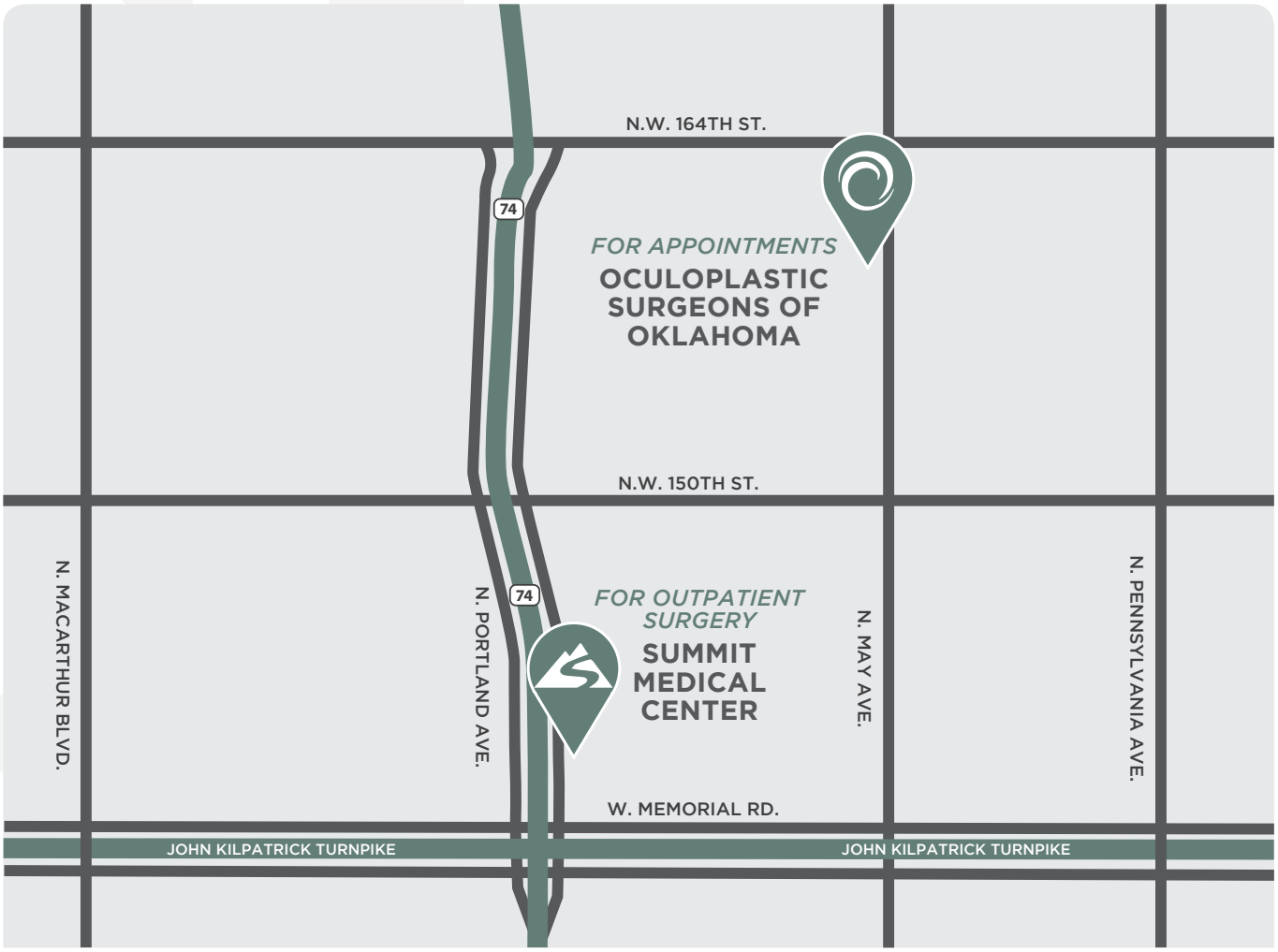
PHONE 405.521.0041 **FAX 405.521.1689** **OCULOSURGEONS.COM**

OCULOPLASTIC SURGEONS OF OKLAHOMA, PLLC

FACILITY LOCATIONS

FOR APPOINTMENTS
OUR OFFICE
16315 N. May Avenue
Edmond, OK 73013
405.521.0041

FOR OUTPATIENT SURGERY
SUMMIT MEDICAL CENTER
14000 N. Portland Avenue, Suite 100
Oklahoma City, OK 73134
405.936.8100



APPOINTMENT CHECKLIST

- ✓ Please arrive 20 minutes early to your appointment.
- ✓ Bring all included forms in this packet.
- ✓ Be sure to have your photo id and insurance cards READY upon arriving to expedite your wait time.
- ✓ Please bring ANY and ALL medication, allergy, and surgery lists you may have to your appointment.
- ✓ If you need to reschedule or cancel your appointment, kindly give our office a 24 notice.
- ✓ You can reach us at **405-521-0041** if you have any questions.

WE LOOK FORWARD TO SEEING YOU!

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16315 N. MAY AVE | EDMOND, OK 73013
405-521-0041

Patient Information as of _____ (enter today's date)

(Please Print Legibly & Fill In or Correct All Fields)

Patient Name _____
Last First Middle

Address _____
Street & Apt # CIty State Zip

Home Phone _____ Cell Phone _____

Any restriction for contacting you? ☐ Yes ☐ No E-mail _____

Contact Restrictions _____

Age _____ Birthdate _____ SS#_____ Sex ☐ Male ☐ Female

Marital Status ☐ Single ☐ Married

Patient's Employer _____ Occupation _____

Work Phone _____ Ext. _____ Is it okay to call at work? ☐ Yes ☐ No

Address _____
Street & Apt # CIty State Zip

Emergency Contact (Not in your household) _____

Relationship to patient _____

Home Phone _____ Work Phone _____ Other Phone _____

Address _____
Street & Apt # CIty State Zip

I understand that office visit charges are payable on the day service is rendered. I authorize Dr. «Doctor_Last_Name» to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Dr. «Doctor_Last_Name» and myself.

You agree, in order for us to service our account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any e-mail address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

Please list any person(s) we are permitted to release private health information regarding your care and/or billing.

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

I have read this disclosure and agree that I may be contacted as described above.

Signature _____ **Date** _____

HEALTH HISTORY

Date _____ **Patient Name** _____ Weight _____Height _____

Have you experienced?	YES	NO	If yes, please explain briefly
Sudden Onset of Weight Loss or Gain			
Increased Fatigue			
Difficulty with your Vision			
Difficulty Swallowing			
Chest Pains			
Skin Rashes for no Apparent Reason			
Bruise Easily or Take Blood Thinners			
Use Tobacco Products			
Consume Alcoholic Beverages			
Heart Arrhythmia?			
Hypertension?			
Heart Valve Problems or Pacemaker			
Do you have a Defibrillator			
Asthma, Emphysema, Sleep Apnea			
Acid Reflux Disease			
Urinary Tract Infections, Kidney Stones			
Cancer, including Skin Cancer			
Arthritis: Rheumatoid/Osteo			
Bleeding Disorder			
Diabetes			
Thyroid Disease, other Chronic Conditions			
Problems with Anesthesia			

FAMILY HISTORY: Does any member of your immediate family have? If so, who?	
Arthritis?	Glaucoma?
Cancer?	Macular degeneration?
Heart disease?	Retinal detachment?
High Blood Pressure?	Stroke/TIA?
Diabetes?	Anesthesia complications?

Past Surgeries, Trauma or Hospitalizations	
	Date:
	Date:
	Date:
	Date:

Current Medications:(including aspirin, herbs and supplements)		
Med:	Dose:	X per day:
Med:	Dose:	X per day:
Med:	Dose:	X per day:
Med:	Dose:	X per day:

Allergies or sensitivity to medicines;			
Drug:	Reaction:	Drug:	Reaction:
Drug:	Reaction:	Drug:	Reaction:
Pharm:		Phone#:	

FACIAL SKIN HISTORY

Name _____
Last First Middle

Address _____
Street & Apt # CIty State Zip

Home Phone _____ Business Phone _____

Age _____ Referred by _____

What problem are you consulting for?

- ☐ Cosmetic facial surgery
- ☐ Sun spots
- ☐ Wrinkles
- ☐ Enlarged blood vessels
- ☐ Other _____

What skin care products do you currently use?

_____ (Cleanser)
_____ (Moisturizer)
_____ (Anti-aging)
_____ (Sunblock SPF _ daily)

How long have you noticed this problem?	☐ Yes	☐ No
Have you ever been treated for this problem	☐ Yes	☐ No
If yes when?_____		
By what method? _____		
Are you currently taking medication for your skin problems?	☐ Yes	☐ No
Are you pregnant, nursing or planning a pregnancy soon?	☐ Yes	☐ No
Do you have a history of keloid scarring?	☐ Yes	☐ No
Have you ever taken Accutane?	☐ Yes	☐ No
Do you have any skin related allergies?	☐ Yes	☐ No
If yes, please specify _____		
Do you wear contact lenses?	☐ Yes	☐ No
Do you have a history of cold sores or fever blisters?	☐ Yes	☐ No

Mark your skin type (when exposed to the sun for about 1 hour with no protection)

- ☐ Always burns, never tans (almost albino skin)
- ☐ Usually burns
- ☐ Sometimes burns, sometimes tans
- ☐ Always tans
- ☐ Rarely burns
- ☐ Never burns

When were you last exposed to the sun or tanning booth?	☐ Yes	☐ No
Do you use chemical suntanning lotions?	☐ Yes	☐ No
Are you planning a holiday in the sun?	☐ Yes	☐ No
Have you ever had skin resurfacing or rejuvenation or chemical peels?	☐ Yes	☐ No
If yes, when and what kind? _____		
Have you ever had treatments for pigmented lesions?	☐ Yes	☐ No
Prior treatment (if any) _____		
Have you ever smoked or used tobacco?	☐ Yes	☐ No
Do you use tobacco now? If yes, How much?_____ pkg. per day	☐ Yes	☐ No
Do you use nicotine supplements now? (for example: Nicoban chewing gum)	☐ Yes	☐ No
If you do not use tobacco products now, when di you quit?_____months/years ago		
Do you consume alcohol?	☐ Yes	☐ No

Patient Signature _____ **Date** _____

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PHOTO USE RELEASE FORM

I,_____ , hereby grant and authorize Oculoplastic Surgeons of Oklahoma, PLLC the right to take, edit, alter, copy, exhibit, publish, distribute and make use of any and all pictures or video taken of _____ to be used in and/or for presentations, legally promotional materials including, but not limited to, newsletters, flyers, posters, brochures, advertisements, fundraising letters, annual reports, press kits and submissions to journalists, websites, social networking sites and other print and digital communications, without payment or any other consideration. This authorization extends to all languages, media, formats and markets now known or hereafter devised. This authorization shall continue indefinitely, unless I otherwise revoke said authorization in writing.

I understand and agree that these materials shall become the property of Oculoplastic Surgeons of Oklahoma, PLLC and will not be returned.

I hereby hold harmless, and release Oculoplastic Surgeons of Oklahoma, PLLC from all liability petitions, and causes of action which I, my heirs, representative, executors, administrators, or any other persons may make while acting on my behalf or on behalf of my estate.

If the person signing is under the age of consent, then this release must be signed by a parent or guardian, as follows:

I hereby certify that I am the parent or guardian of named above, and do hereby give my consent without reservation to the foregoing on behalf of this individual.

Signature _____ **Date** _____