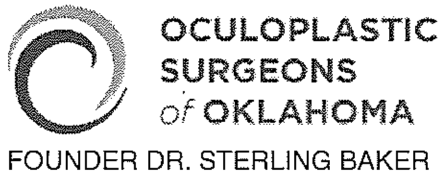

FOUNDER DR. STERLING BAKER

ERIN L. HOLLOMAN, M.D. I DIANA A. TAMBOLI, M.D. I ENSA K. PILLOW, MD I
CHRISTINA HIERSCHE, PA-C I LAUREN ADUDDELL, PA-C

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. Please ask us if you have any questions, comments or need further information 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, founder Dr. Sterling Baker,
Dr. Erin Holloman, Dr. Diana Tamboli, Dr. Ensa Pillow, Christina Hiersche, PA-C and
Lauren Aduddell, PA-C.

16315 N. MAY AVENUE, EDMOND, OK 73013

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

OCULOPLASTIC SURGEONS OF OKLAHOMA, PLLC

Appointment Checklist

- 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 lists, allergy lists, and surgery lists you may have to your appointment. You may have your pharmacy fax us your medication list to (405) 521-1689.

- If you need to reschedule or cancel your appointment, kindly give our office a 24 HOUR notice.

- You can reach us at (405) 521-0041 if you have any questions.

- **IF YOU ARE COMING IN FOR AN UPPER EYE LID SURGERY CONSULTATION, WE RECOMMEND *NO* BOTOX INJECTIONS WITHIN 90 DAYS OF YOUR CONSULTATION APPOINTMENT.**

WE LOOK FORWARD TO SEEING YOU!

OCULOPLASTIC SURGEONS OF OKLAHOMA
16315 N. May Avenue
Edmond, OK 73013
405-521-0041

Patient Information as of ________________ (enter today's date)
(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name ____
Last First Middle

Address ____
Street & Apt # City State Zip

Home Phone ____________________ Cell Phone ____________________

Any restrictions for contacting you? No ___ Yes ___ ***E-MAIL*** ____________________

Contact restrictions: ____________________

Age ________ Birthdate ________ SS# ____________ Sex [ ] Female [ ] Male

Marital Status [ ] Single [ ] Married Spouse's Name: ____________________

Spouse's Phone #: ____________________

Patient's Employer ____________________ Occupation ____________________

Work Phone ____________ Ext: ________ Is it okay to call you at work? [ ] Yes [ ] No

Address ____
Street & Suite # City State Zip

Emergency Contact
(Not in your household) ____________________ Relationship to Patient ____________________

Home Phone ____________________ Cell Phone ____________________

Primary Insurance ____

Policy Holder Name: ____________________ Date of Birth ____________
Last First MI

Secondary Insurance ____

Policy Holder Name: ____________________ Date of Birth ____________
Last First MI

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

Name	Relationship	Phone
Name	Relationship	Phone

I understand that office visit charges are payable on the day service is rendered. I authorize Dr. ________________ 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. ____________________ and myself.

We are happy to file any insurance on your behalf, but please be aware that we **DO NOT participate in all plans.** If you are uncertain if our office participates in your plan, you should call the customer service number listed on the back of your card and ask them directly. **Many companies are now offering multiple plans, and some have a closed network. We are not able to confirm or deny our participation with any certainty.**
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. This includes 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 us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

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

Signature ____ **Date** ________________

DATE:_______________

HEALTH HISTORY

Weight:__________
Height:__________

Patient Name:_______________________________________

Have you experienced?	Yes	No	If yes, please explain briefly
1. Sudden onset of weight loss or gain?			
2. Increased fatigue?			
3. Difficulty with your vision?			
4. Difficulty swallowing?			
5. Chest pains?			
6. Skin rashers for no apparent reason?			
7. Bruise easily or take blood thinners?			
8. Use tobacco products?			
9. Consume alcoholic beverages?			
10. Heart arrhythmia?			
11. Hypertension?			
12. Heart valve problems or pacemaker?			
13. Do you have a defibrillator?			
14. Asthma? Emphysema? Sleep apnea?			
15. Acid reflux disease?			
16. Urinary tract infections? Kidney stones?			
17. Cancer, including skin cancer?			
18. Arthritis: Rheumatoid/Osteo			
19. Bleeding disorder?			
20. Diabetes?			
21. Thyroid disease? Other Chronic conditions?			
22. 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
	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:
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:

Preferred Pharmacy:_______________________________ Phone #:____________________

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16315 N. May Avenue
Edmond, OK 73013
9821 S. May Ave. Ste C
Oklahoma City, OK 73159
Phone: 405-521-0041 Fax: 405-521-1689

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.

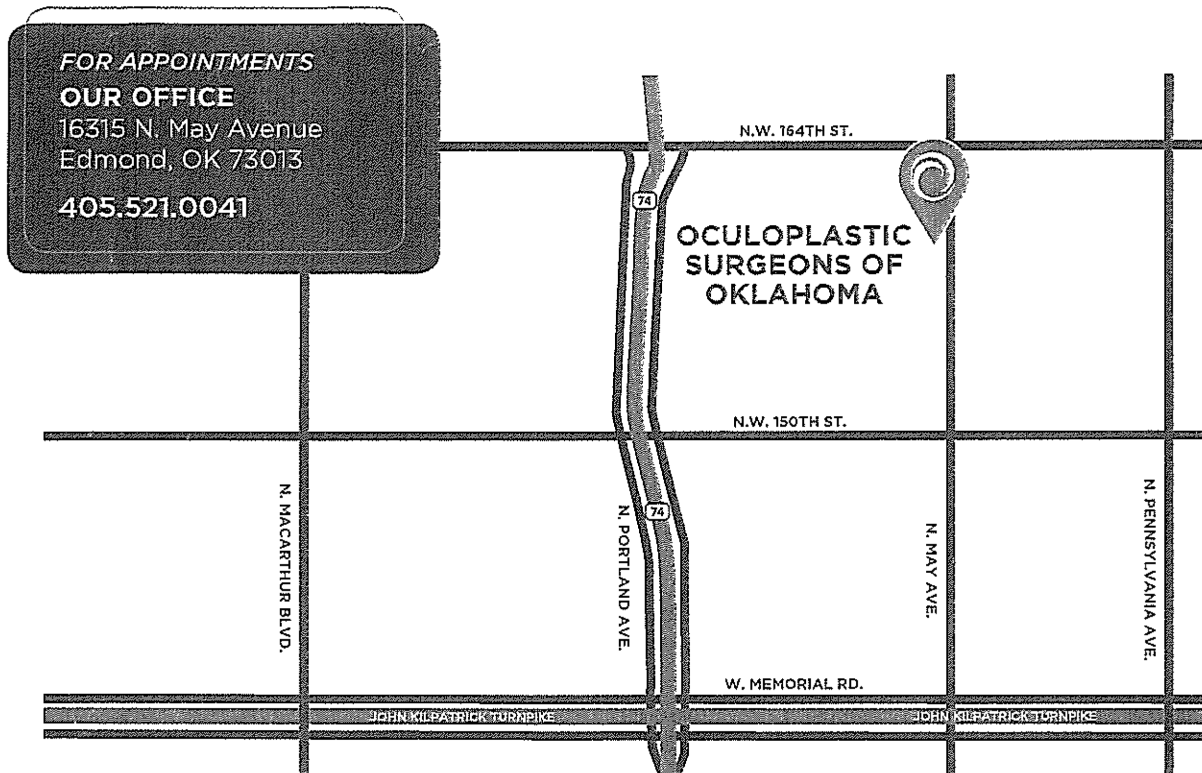
If the person signing is under the age of consent, then this release must be signed by a parent or guardian, as follows:

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)

OCULOPLASTIC
SURGEONS
of OKLAHOMA

DIRECTIONS



From I-35

Take westbound Kilpatrick Turnpike exit

Travel westbound to May Ave

Take May Ave exit

Turn right onto May Ave

Travel northbound on May Ave for approximately 2 miles

The Oculoplastic Surgeons of Oklahoma office will be on your left, just south on NW 164th St

From I-40

Take eastbound I-44 exit towards Tulsa

Travel eastbound I-44 to the I-44/OK-74 split (approximately 3 miles)

Take OK-74 (Lake Hefner Parkway) northbound

Travel northbound on OK-74 for approximately 8 miles

Take NW 150th St exit

Turn right onto NW 150th St

Travel eastbound on NW 150th St for 1 mile

Turn left onto May Ave

Travel northbound on May Ave for approximately 1 mile

The Oculoplastic Surgeons of Oklahoma office will be on your left, just south of NW 164th St

From I-44/HE Bailey Turnpike

Travel eastbound I-44 to the I-44/OK-74 split (approximately 3 miles north of I-40 Junction)

Take OK-74 (Lake Hefner Parkway) northbound

Travel northbound on OK-74 for approximately 8 miles

Take NW 150th exit

Turn right onto NW 150th St

Travel eastbound on NW 150th St for 1 mile

Turn left onto May Ave

Travel northbound on May Ave for approximately 1 mile

The Oculoplastic Surgeons of Oklahoma office will be on your left, just south of NW 164th St

From I-44/Turner Turnpike

Take westbound Kilpatrick Turnpike exit

Travel westbound to May Ave

Take May Ave exit

Turn right onto May Ave

Travel northbound on May Ave for approximately 2 miles

The Oculoplastic Surgeons of Oklahoma office will be on your left, just south of NW 164th St