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 rashes 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 #:_____

OCULOPLASTIC SURGEONS OF OKLAHOMA

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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 picture(s) or video(s) taken of myself 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)