ARTISAN MD
EYELID & FACIAL
PLASTIC SURGERY

Patient Registration Form

Last Name: _____ **First Name:** _____ **MI:**_____ **Age:**_____

Date of Birth: _____ **Social Security #:** _____

Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Widowed **Gender:** ◯ Male ◯ Female

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Cell Phone: _____ **Home Phone:** _____ **Email:** _____

Employer: _____ **Occupation:** _____ **Work Phone:** _____

Emergency Contact

Name: _____ **Relationship:** _____

Address: _____ **Phone #:** _____

Referring Doctor's Name & Phone: _____

Pharmacy Name / Location:	**Pharmacy Phone #:**

Insurance Information

Insurance Subscriber: ◯ Self ◯ Other (*name*): _____

PRIMARY Insurance: _____ **ID #:** _____

Policyholder's Name: _____ **Group #:** _____

Policyholder's DOB: _____ **SS #:** _____ **Relationship:** _____

SECONDARY Insurance: _____ **ID #:** _____

Policyholder's Name: _____ **Group #:** _____

Policyholder's DOB: _____ **SS #:** _____ **Relationship:** _____

Workers Compensation: ☐ Yes - **Accident Date:** _____ **Claim #:** _____ **Contact Name:** _____ **PH:** _____
Auto Accident Insurance: ☐ Yes - **Accident Date:** _____ **Claim #:** _____ **Contact Name:** _____ **PH:** _____

I, the undersigned authorize payment of medical benefits to Laryssa Dragan,MD, Artisan MD,PLLC. for any services furnished to me. I understand that I am financially responsible for any amount not covered by my contract. I also authorize the release to my insurance company or their agent information concerning health care advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

✖ _____ _____
Patient, Parent or Guardian SIGNATURE Date

(**MEDICARE** patients please **ALSO sign below**) *Medicare Lifetime Signature on File*

I request that payment of authorized Medicare Benefits be made on my behalf to Laryssa Dragan, M.D., Artisan MD, PLLC. for any services rendered. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information to determine these benefits payable for related services.

✖ _____ _____
Patient SIGNATURE Date

Please check how you heard of us: ☐ Referring doctor ☐ Website ☐ Emergency Room ☐ Friend/Relative_____ ☐ Other_____

Authorization to Use or Disclose Protected Health Information For Purposes Other than Treatment, Payment or Healthcare Operations

I, _____, understand Artisan MD Eyelid & Facial Plastic Surgery is
(*Print Name*)
authorized by me to use or disclose my protected health information for treatment, payment or health care operations only. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information and the recipient(s) of that information. I specifically authorize any current employee or owner at Artisan MD PLLC, or any other individual listed below to disclose my protected health information as described on this form to the recipients listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization.

I understand, and authorize my health care provider to use my name, address and phone number; the name of my scheduled treating physician; and the time and place of my scheduled appointment(s), for the limited purpose of contacting me to notify me of a pending appointment or other healthcare related communication. I also authorize my healthcare provider to disclose to third parties who answer my phone limited protected health information regarding pending appointments and to leave a reminder message on my voice mail system or answering machine.

Do you give us <u>permission to discuss your medical</u> and <u>financial information</u> with family members and/or friends?
◯No ◯Yes (Please list the friends/ family members that you would like to authorize us to speak to)

Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number

Do you give us permission to <u>leave you a PHONE message</u> with protected health information?
◯No ◯Yes (☐ Mobile Phone ☐ Home Phone)

Patient's SIGNATURE _____ Date: _____

<u>(FOR OFFICE USE ONLY)</u>
I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date:_____ Initials:_____
Reason:_____

ARTISAN MD
EYELID & FACIAL
PLASTIC SURGERY

MEDICAL HISTORY FORM / Review of SYSTEMS

Name: _____ **Date:** _____ **DOB:** _____ **Age:** _____

Height: _____ FT. ____ in. **Weight**: _____ lbs

Name and **city** of your **EYE** doctor: _____
Name and **city** of your **PRIMARY CARE** physician: _____
Name and **city** of your **CARDIOLOGIST** (heart):_____
Name and **city** of your **PULMONOLOGIST** (lung): _____
Name and **city** of your **ENDOCRINOLOGIST:** _____

Review of Systems: Please check ANY that may apply to YOU – OR – ☐ I do **NOT** have any medical issues

CONSTITUTIONAL
- ☐ Recent fevers/sweats
- ☐ Unexplained weight loss/gain
- ☐ Unexplained fatigue/weakness

EYE HISTORY
- ☐ Eye disease_____
- ☐ Double vision
- ☐ Dry eyes
- ☐ Baggy/Droopy eyelids
- ☐ Tearing
- ☐ Lazy eye
- ☐ Eye injury/trauma
- ☐ Glaucoma
- ☐ Retinal disease
- ☐ Cataract surgery (date)_____
- ☐ Contact lenses
- ☐ Other_____

EAR, NOSE, THROAT
- ☐ Hard of hearing
- ☐ Hay fever/allergies
- ☐ Sinus Problems
- ☐ Trouble swallowing

LUNGS
- ☐ Asthma
- ☐ **COPD**
- ☐ **Sleep Apnea** (CPAP? YES or NO)
- ☐ **Oxygen use**_____

URINARY ☐ Urinary problems

MUSKULOSKELETAL
- ☐ **Joint replacement**_____
  Do you need to take antibiotics when you see a dentist? ○ *YES* ○ *NO*
- ☐ Arthritis / Swollen joints

GASTROINTESTINAL (GI)
- ☐ Heartburn
- ☐ Frequent diarrhea
- ☐ Frequent vomiting

SKIN
- ☐ Rashes
- ☐ Skin cancer - what kind?
  - ☐ Basal Cell
  - ☐ Squamous Cell
  - ☐ Melanoma

NEUROLOGIC
- ☐ Headaches
- ☐ Seizures
- ☐ **History of stroke/TIA**
- ☐ Neurologic disease (MS,MG etc)

PSYCHIATRIC
- ☐ Anxiety
- ☐ Depression

ENDOCRINE
- ☐ Hypothyroid
- ☐ Hyperthyroid
- ☐ **DIABETES** ☐ INSULIN ☐ ORAL MEDS

CARDIOVASCULAR
- ☐ **Cardiac stents** _____
- ☐ Heart attack
- ☐ Chest pain
- ☐ **Atrial fibrillation**
- ☐ **Irregular heartbeat**
- ☐ **Heart murmur**
- ☐ High cholesterol
- ☐ CHF
- ☐ High blood pressure
- ☐ **artificial Heart Valve replacement**____
- ☐ **Pacemaker** ***
- ☐ **Defibrillator** ***

HEMATOLOGY / ONCOLOGY
- ☐ **Blood disorders / clot**
- ☐ Anemia
- ☐ Cancer type_____
  treatment: _____

INFECTIONS + AUTOIMMUNE
- ☐ Hepatitis A, B, C (circle)
- ☐ HIV
- ☐ **History of MRSA,** if applicable:
  when? _____
- ☐ Lupus
- ☐ Sjogrens
- ☐ Rheumatoid Arthritis

FEMALES
- ☐ pregnant
- ☐ breast feeding

Have you ever had any complications with anesthesia? ○ No ○ Yes: _____

SURGICAL HISTORY: List **ALL** previous **surgeries** **-OR-** ☐ I have **NEVER had surgery**

1._____ 3._____ 5._____
2._____ 4._____ 6._____

MEDICAL HISTORY: List **ALL illnesses / disease** which you have had, or have now

1._____ 2._____ 3._____
2._____ 4._____ 6._____

_____ _____
Reviewed by physician *Date* **Patient** (*or patient representative*) **SIGNATURE** (***cont. to next page*** →)

Name: ______________________________ **DOB:** ____________ **Date:** __________________

FAMILY HISTORY: *(list who had this)*

Diabetes ○Yes ○No ______________________

Arthritis ○Yes ○No ______________________

Cancer ○Yes ○No ______________________

Eye Disease ○Yes ○No ______________________

High Blood Pressure ○Yes ○No ______________________

SOCIAL HISTORY:

Do you **SMOKE**? ○Current smoker__________ ○Former smoker ○Non-smoker

Do you drink **ALCOHOL** ○No ○Yes – drinks per day? __________________

Do you use recreational **DRUGS** ○No ○Yes______________________

ALLERGIES: ○YES (please list reaction) -or- ○NO ALLERGIES

- ☐ Penicillin_____________________________________
- ☐ Sulfa____
- ☐ Latex____
- ☐ Iodine____
- ☐ Codeine ______________________________________
- ☐ Others____

MEDICATIONS

Please list **ALL MEDICATIONS** you are currently taking, including **SUPPLEMENTS** *(for example, vitamins)* and **OVER-THE-COUNTER.**

Medication Name	**Dose**	**Frequency**

Are you taking any blood thinners? ☐ **Aspirin** ☐ **Coumadin (warfarin)** ☐ **Plavix** ☐ **Eliquis** ☐ **Other**______________________

Are any of the medications that you are taking for the treatment of ADD/ADHD or Weight Loss?
If YES, list here: ____

____ ✖ ____

Reviewed by physician Date Patient (or patient representative) SIGNATURE

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(OFFICE USE ONLY) Patient's history reviewed:

Initials / Date ____________________ ○No Change ○Updated ______________________________

Initials / Date ____________________ ○No Change ○Updated ______________________________

Initials / Date ____________________ ○No Change ○Updated ______________________________

Initials / Date ____________________ ○No Change ○Updated ______________________________

Initials / Date ____________________ ○No Change ○Updated ______________________________
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