

Elite Oculoplastic Surgery, PC  
Michelle H. White, MD  
5690 DTC BOULEVARD, SUITE 130W  
GREENWOOD VILLAGE, COLORADO 80111  
OFFICE PHONE: 303-500-5042

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone: Home \_\_\_\_\_ Cell \_\_\_\_\_ Can we leave a Message Y / N

**\* Email address:**

Occupation: \_\_\_\_\_ Preferred Contact Method: \_\_\_\_\_

**EMERGENCY INFORMATION**

Person to Notify \_\_\_\_\_ Relationship \_\_\_\_\_

Telephone: Work/Home/Cell \_\_\_\_\_

If Patient is a child: Father Name \_\_\_\_\_ Telephone Home \_\_\_\_\_ Work \_\_\_\_\_

Mother Name \_\_\_\_\_ Telephone Home \_\_\_\_\_ Work \_\_\_\_\_

**REFERRAL INFORMATION**

Who sent you to our office? \_\_\_\_\_ Telephone \_\_\_\_\_

**PHYSICIAN INFORMATION**

GeneralMD \_\_\_\_\_ Telephone \_\_\_\_\_

Pharmacy Address: \_\_\_\_\_ Telephone \_\_\_\_\_

Other Specialist Doctors (eye, glasses, cardiology, endocrine, cancer, plastic surgery, etc):

Ophthalmologist \_\_\_\_\_ M.D. Telephone \_\_\_\_\_

Optometrist \_\_\_\_\_ O.D. Telephone \_\_\_\_\_

Name \_\_\_\_\_ Specialty \_\_\_\_\_ Telephone \_\_\_\_\_

**INSURANCE INFORMATION: Please have insurance cards and ID/Driver's License ready to scan**

**Primary Insurance** \_\_\_\_\_ Subscriber \_\_\_\_\_

ID #: \_\_\_\_\_ Group # \_\_\_\_\_

Subscriber Date of Birth \_\_\_\_\_ Subscriber SSN# \_\_\_\_\_

Patient's Relationship to Subscriber \_\_\_\_\_

**Secondary Insurance** \_\_\_\_\_ ID# \_\_\_\_\_

Subscriber name \_\_\_\_\_ Subscriber DOB \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

**1. Please list all medications you take on a regular basis:**

(Please include any eye drops, vitamins, herbs, or over the counter products such as aspirin or aspirin containing products.)

<u>Medication</u>	<u>Strength/Dose</u>	<u>Frequency</u>
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		
6. _____		
7. _____		
8. _____		

**2. Please list all illnesses/diseases which you have had or have now:**

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_

**3. Please list all prior surgeries or procedures:**

<u>Surgery</u>	<u>Physician</u>	<u>Approximate Date</u>
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		

**4. Please list any allergy or sensitivity to medication or food:    None**

<u>Medication</u>	<u>Reaction</u>
1. _____	
2. _____	
3. _____	
4. _____	

Patient Name: \_\_\_\_\_

5. Has anyone in your family had the same problem that brings you to our office?  Yes  No

If yes, who? \_\_\_\_\_

Do any of these diseases run in your family. If YES, please note relationship

\_\_\_ Glaucoma \_\_\_\_\_  
\_\_\_ Diabetes \_\_\_\_\_  
\_\_\_ Heart Disease \_\_\_\_\_  
\_\_\_ High blood pressure \_\_\_\_\_  
\_\_\_ Skin cancer \_\_\_\_\_  
\_\_\_ Other \_\_\_\_\_

Do you smoke? Y / N  
If YES, how much \_\_\_\_\_

Drink alcohol? Y / N  
If YES, how much? \_\_\_\_\_

6. Do any of the following problems apply to you? If YES, please explain.

<b>Constitutional</b> (fever, weight loss, poor appetite, etc.)	<input type="checkbox"/> yes <input type="checkbox"/> no	
<b>Eyes</b> (glaucoma, cataract, lazy eye, retina problems, etc)	<input type="checkbox"/> yes <input type="checkbox"/> no	
<b>Ear/Nose/Throat</b> (hearing loss, sinus problems, sore throat, frequent bloody noses, etc)	<input type="checkbox"/> yes <input type="checkbox"/> no	
<b>Cardiovasc</b> (heart problems, chest pain, high blood pressure, stroke, pacemaker, heart surgery)	<input type="checkbox"/> yes <input type="checkbox"/> no	
<b>Respiratory</b> (asthma, shortness of breath, wheezing, coughing, etc)	<input type="checkbox"/> yes <input type="checkbox"/> no	
<b>Gastro-intestinal</b> (heartburn, diarrhea, vomiting, abdominal pain, etc)	<input type="checkbox"/> yes <input type="checkbox"/> no	
<b>Genito-urinary</b> (urinary problems, blood in urine, etc)	<input type="checkbox"/> yes <input type="checkbox"/> no	
<b>Skin</b> (skin rashes, excessive dryness, used Accutane, skin cancer/diseases, etc)	<input type="checkbox"/> yes <input type="checkbox"/> no	
<b>Musculoskeletal</b> (muscle aches, joint pain, swollen joints, artificial joint, arthritis, etc)	<input type="checkbox"/> yes <input type="checkbox"/> no	
<b>Neurological</b> (numbness, weakness, paralysis, headaches, spasm, MS, etc)	<input type="checkbox"/> yes <input type="checkbox"/> no	
<b>Hematologic</b> (blood disorders, leukemia, easy bleeding/bruising, take aspirin, etc)	<input type="checkbox"/> yes <input type="checkbox"/> no	
<b>Allergy</b> (hay fever, seasonal allergies, etc)	<input type="checkbox"/> yes <input type="checkbox"/> no	
<b>Endocrine</b> (thyroid or pituitary problems, etc)	<input type="checkbox"/> yes <input type="checkbox"/> no	
<b>Psychiatric</b> (depression, anxiety, etc)	<input type="checkbox"/> yes <input type="checkbox"/> no	
Hepatitis B or C, HIV or AIDS, Tuberculosis, etc	<input type="checkbox"/> yes <input type="checkbox"/> no	
Diabetes, radiation treatments, anesthesia problems, etc.	<input type="checkbox"/> yes <input type="checkbox"/> no	

Other Comments: \_\_\_\_\_

Physician Initials \_\_\_\_\_ Date \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

*Elite Oculoplastic Surgery, PC  
Michelle H. White, MD*

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT AND CONSENT**

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information.

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly/indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your *Notice of Privacy Practices* containing a more complete *description of the uses and disclosures of my health information*. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

*Elite Oculoplastic Surgery, PC*  
*Michelle H. White, MD*

By signing below, I authorize Michelle H. White, MD to give me reasonable and proper medical care by today's standard. I understand that all charges are payable on the day service is rendered if not covered by insurance. **I understand it is my responsibility to verify with my insurance carrier that Michelle H. White is a participating provider with my insurance plan.** I authorize Elite OculoPlastic Surgery, PC 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 Elite OculoPlastic Surgery, PC and myself.

Authorization: I hereby authorize Elite OculoPlastic Surgery, PC to release any medical or other necessary information insurance carriers require in either paper or digital form concerning my personal health information. I hereby irrevocably assign all payments for all services rendered to Elite OculoPlastic Surgery, PC I also request payment of government benefits either to myself or to Elite OculoPlastic Surgery, PC.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_