Schaefer Oculofacial Plastic Surgery, PLLC
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Buffalo, NY 14209
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https://BuffaloEyePlastics.com

PATIENT REGISTRATION

Appointment: _____

Please complete this form and mail to the above address or email to info@BuffaloEyePlastics.com . You may also bring this completed form to your appointment.

Name: Last _____ First _____ Middle _____

Preferred Name to be greeted by _____

Gender: male female prefer not to say other: _____

Date of Birth _____ Social Security # _____

Guardian (if applicable) _____

Street Address _____

City _____ State _____ Zip Code _____

Phone: Home _____ Work _____ Mobile _____

Consent to Text: yes no

Email _____ Providing your email will assist with your access to online health records, secure messaging with the doctor, and appointment reminders.

Preferred Method of Contact: Home Work Mobile Email Mail

Preferred Language: English Other _____

Race: American Indian/ Alaskan Native Asian Black/African American Native Hawaiian White
Other: _____ Prefer Not to Say

Ethnicity: Hispanic or Latino NOT Hispanic or Latino Unknown Prefer Not to Say

Marital Status: Single Married Widow Divorced

Emergency Contact _____ Relationship _____ Phone _____

Patient Name _____ Date of Birth _____

Employer's Name _____ Phone _____

Address _____

Occupation _____

Primary Insurance _____ Policy ID # _____

Relation of Insured: Self Spouse Parent Other: _____

Name of Subscriber _____ DOB of Subscriber _____

Secondary Insurance _____ Policy ID # _____

Relation of Insured: Self Spouse Parent Other: _____

Name of Subscriber _____ DOB of Subscriber _____

How did you hear about us? _____

Referring Doctor _____ Phone _____

Address _____

Would you like our clinic notes sent to this provider? Yes No

Family Doctor _____ Phone _____

Address _____

Would you like our clinic notes sent to this provider? Yes No

Preferred Facilities:

Pharmacy _____ Phone _____

Address _____

Laboratory (blood work) _____ Phone _____

Address _____

Imaging Facility _____ Phone _____

Address _____

Patient Name _____ Date of Birth _____

Insurance Authorization:

I certify that I (or my dependent) have insurance coverage as stated above and agree to have insurance payments made directly to Schaefer Oculofacial Plastic Surgery, PLLC to be applied to my account for services rendered. I understand that I am financially responsible for all charges incurred in the event that my insurance denies payments. For patients covered by Medicare: I understand that I will be responsible for 20% of the Medicare allowable charges plus any deductibles, coinsurance and uncovered charges that apply.

I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____

Patient Signature Date

Financial Policy Acknowledgement:

I have been provided a copy of the Financial Policy to read. I understand the policy and agree that in return for the services provided by Schaefer Oculofacial Plastic Surgery, PLLC, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Schaefer Oculofacial Plastic Surgery, PLLC for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to Schaefer Oculofacial Plastic Surgery, PLLC. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Schaefer Oculofacial Plastic Surgery, PLLC. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill. I also acknowledge that non-payment of my account may result in collections proceedings and dismissal from the practice.

I understand that if I fail to appear for my scheduled appointment, I will be charged a fee of $50.00 unless I cancel the appointment with at least 24 hours' notice. I understand that payment of non-covered services co-pays and deductibles are expected at the time of service.

_____ _____

Patient Signature Date

HIPPA Acknowledgement:

I have been provided with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I authorize the practice to use and disclose my health information and other protected health information for purposes of treating me, obtaining payment for services rendered to me and conducting healthcare operations. I permit a copy of this authorization to be used in place of the original.

Schaefer Oculofacial Plastic Surgery, PLLC may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation of which (1) is or may be liable or under contract to Schaefer Oculofacial Plastic Surgery, PLLC for reimbursement for services rendered, and (2) any health care provider for continued patient care.

Schaefer Oculofacial Plastic Surgery, PLLC may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to state or federal law, statue or regulation. A copy of this authorization may be used in place of the original. I authorize that my protected health information (also known as PHI) may be used or disclosed with the above-mentioned people. I understand that I have the right to be aware of all PHI that will be disclosed to these people. I understand that Schaefer Oculofacial Plastic Surgery, PLLC will not condition any aspect of my treatment or payment. I understand that I am under no obligation to sign this Authorization. I understand that this Authorization may be revoked in writing at any time by my signing a revocation statement and returning it to Schaefer Oculofacial Plastic Surgery, PLLC unless: they have previously acted in reliance on this Authorization.

By signing the Authorization, I acknowledge that I have read and understand this Authorization. Further, I give my authorization to Schaefer Oculofacial Plastic Surgery, PLLC to use or disclose PHI in accordance to the terms of the Authorization.

_____ _____

Patient Signature Date

Medication History Consent:

I understand that my medication history may be obtained utilizing an electronic information exchange and that this protected health information may provide valuable information for my healthcare provider.

I hereby authorize Schaefer Oculofacial Plastic Surgery, PLLC to access my medication history without limitation or exclusion as is required and/or reasonably advisable to disclose, process, retrieve, transmit, and view for the purpose of the transmission of an electronic prescription issued by a provider authorized by law to prescribe, as necessary for my care and treatment.

_____ _____

Patient Signature Date

Authorization for Schaefer Oculofacial Plastic Surgery, PLLC to Disclose My Health Information:

Schaefer Oculofacial Plastic Surgery, PLLC may use or disclose my health care information to the below individuals such as family and/or friends. You do not need to list your doctors.

Name _____ Phone _____

Name _____ Phone _____

Name _____ Phone _____

II. My Rights: This authorization has no expiration date. I may revoke this authorization at any time, in writing, sent to Schaefer Oculofacial Plastic Surgery, PLLC. Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it. I am aware that I can request a copy of this authorization after I have signed it.

_____ _____

Patient Signature Date

PAST MEDICAL HISTORY

Name _____ DOB _____ Today's Date _____

Allergies to MEDICATIONS: Yes No Please list and describe reaction.

_____

_____

Are you allergic to latex? Yes No

List any MEDICATIONS you take now. Include all non-prescription drugs and vitamins.

Name of Medication	Strength	How many times a day?	Reason for taking
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Have you recently had: A fever yes no Unintentional Weight Loss yes no

Medical History: Please explain checked items.

Autoimmune (lupus etc) _____

Body/lymph (anemia, HIV, etc) _____

Cancer _____

Ears/nose/throat _____

Endocrine (**diabetes**, hypothyroid, hyperthyroid, Grave's Disease, etc) _____

Gastrointestinal (Chrohns, Ulcerative colitis, etc) _____

Heart (high or low blood pressure, high cholesterol, etc) _____

Muscles, Bones, Joints (osteoporosis, arthritis etc) _____

Neurological (stroke, multiple sclerosis) _____

Psychiatric (anxiety, depression, etc) _____

Respiratory (apnea, asthma, emphysema, COPD, etc) _____

Skin (eczema, rosacea, psoriasis, etc) _____

How tall are you? _____ What is your approximate weight? _____

Patient Name _____ Date of Birth _____

Social History

Do you drink alcohol? No Occasionally 1 per day 2-3 per day 4+ per day

Do you smoke (including vaping)? Never Former Smoker Current Every Day Smoker Current Some Day Smoker

If previous, _____ years ago.

Use recreational drugs yes no

Eye History Please check below and explain (which eye, when it started, estimated surgery date).

Cataract Surgery _____

Cornea Disease _____

Eyelid Surgery _____

Glaucoma _____

Macular Degeneration or Retina Disease _____

Diabetic Eye Disease _____

Childhood Problems (lazy eye, amblyopia, tearing) _____

Other Eye Surgeries? _____

What is the approximate date of your last dilated eye exam? _____

Do you have double vision? No Yes, when did it begin? _____

Surgical History Any other major surgeries?

_____

_____

Any history of fillers, botox, laser procedures to the face, or other facial procedures?

_____

_____