EYE PLASTIC SURGERY

JAMES S. LINDER, MD, PC

OPHTHALMOLOGY

EYELIDS | TEARING | AESTHETICS

6258 Poplar Ave.
Memphis, TN
38119

901.680.1990 p
901.680.1944 f
www.jslindermd.com

PATIENT INFORMATION

Full Legal Name: _____ (First) (M.I) (Last)			**Prefix:** ❑ Mr. ❑ Ms. ❑ Mrs. ❑ Miss	**Preferred Name:**
Birth Date:	**SSN:**	**Sex:** ❑ Male ❑ Female	**Marital Status:**	**Race:**
Address:	**Apt No.**	**City:**	**State:**	**Zip:**
Home Phone:	**Work Phone:**	**Cell Phone:**		

Is it OK to leave a message on your answering machine regarding your health information? ❑ Yes ❑ No

Email:	**Preferred Contact Method:** ❑ Home Phone ❑ Work Phone ❑ Cell Phone ❑ Email
Employer:	**Employer's Address:**
Emergency Contact Name:	**Relationship:** Phone:
Preferred Pharmacy:	**Pharmacy Phone Number:**
Referred by:	

INSURANCE INFORMATION

PRIMARY		SECONDARY	
Insurance Company:		Insurance Company:	
Claims Address:		Claims Address:	
City, State, Zip:		City, State, Zip:	
Phone:		Phone:	
ID/Policy #:		ID/Policy #:	
Group/Plan #:		Group/Plan #:	

Responsible Party's Name: _____ (First) (M.I) (Last)			**Prefix:** ❑ Mr. ❑ Ms. ❑ Mrs. ❑ Miss	**Sex:** ❑ Male ❑ Female
Birth Date:	**SSN:**	**Relationship to Patient:**		
Address:	**Apt No.**	**City:**	**State:**	**Zip:**
Home Phone:	**Work Phone:**	**Cell Phone:**		
Employer:	**Employer's Address:**			

If you are a member of a managed care plan, please read and sign below:

I have checked with my insurance company and verified that the provider I'm seeing is a participating provider on my insurance plan. If a referral from another provider is required before seeing the providers of James S. Linder, M.D., I agree that it is my responsibility to obtain such a referral. It is also my responsibility to advise the office in advance if precertifications are needed. If my insurance company requires the use of a specific lab, I have listed it above. <u>If any charges remain unpaid because I have not provided the proper information itemized above or because services are not covered by my plan, I agree to be personally liable for those charges.</u>

Signature of Patient/Responsible Party: _____ Date: _____

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PATIENT HISTORY FORM

Name: _____ Date of Birth: _____

PAST MEDICAL HISTORY

Do you now or have you ever had:

- ❑ Diabetes
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Thyroid disease
- ❑ Cancer (type) _____
- ❑ Heart disease
- ❑ COPD
- ❑ Emphysema
- ❑ Asthma
- ❑ Stroke
- ❑ Epilepsy (seizures)
- ❑ Anemia
- ❑ Sleep Apnea
- ❑ Rheumatoid Arthritis
- ❑ HIV/AIDS
- ❑ Kidney disease
- ❑ Glaucoma
- ❑ Cataracts
- ❑ Macular Degeneration

Other medical conditions (please list):

_____

CURRENT MEDICATIONS

Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:

Name of drug	Dosage	Taken For
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Are you allergic to any medications? ❑ Yes ❑ No **If yes, please list:**

FAMILY HISTORY

If any blood relative has had any of the following, please check box and indicate relationship.

❑ Glaucoma	❑ Macular Degeneration	❑ Droopy Lids
❑ Crossed Eyes	❑ Blindness	❑ Other:

SOCIAL HISTORY

Do you drink? ❑ Yes ❑ No If yes, how much?	Do you smoke? ❑ Yes ❑ No If yes, how much?	Are you a former smoker? ❑ Yes ❑ No If so, what year did you quit?

IMMUNIZATION HISTORY

Have you had your flu vaccine? ❑ Yes ❑ No If yes, when?	Have you had a pneumonia vaccine? ❑ Yes ❑ No If yes, when?

Patient signature _____ Date_____

Reviewed by/MD signature_____

OCULAR HISTORY

Please check if you have had any eye surgeries in the past.

❑ Cataract Surgery	❑ Glaucoma Surgery	❑ Retina Surgery	❑ Eyelid Surgery
❑ Tear Duct Surgery	❑ Orbit Surgery	❑ Strabismus Surgery	❑ Other: _____

OTHER SURGICAL HISTORY

Please list any other surgeries you have had in the past.

Type of Surgery	Year	Type of surgery	Year
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

SYSTEMS REVIEW

In the past month, have you had any of the following problems?

CARDIOVASCULAR
- ❑ Chest pain
- ❑ Irregular heart beat
- ❑ Shortness of breath

HEENT
- ❑ Dizziness
- ❑ Hearing loss
- ❑ Hoarseness
- ❑ Ringing in ears
- ❑ Sore throat

MUSCULOSKELETAL
- ❑ Back pain
- ❑ Joint pain
- ❑ Muscle aches
- ❑ Stiffness
- ❑ Swelling

RESPIRATORY
- ❑ Cough
- ❑ Trouble breathing
- ❑ Wheezing

BLOOD PRESSURE
- ❑ Good BP control
- ❑ Borderline BP control
- ❑ Poor BP control
- ❑ Unknown BP control

CONSTITUTIONAL
- ❑ Fatigue
- ❑ Fever
- ❑ Night sweat
- ❑ Weakness
- ❑ Weight loss

HEMATOLOGIC
- ❑ Bleeding
- ❑ Bruising
- ❑ Tender nodes

NEUROLOGICAL
- ❑ Balance problems
- ❑ Headache
- ❑ Numbness
- ❑ Tingling

SKIN
- ❑ Hair loss
- ❑ Rash
- ❑ Skin lesions

DIABETES CONTROL
- ❑ Good DM control
- ❑ Borderline DM control
- ❑ Poor DM control
- ❑ Unknown DM control

GENITOURINARY
- ❑ Genital discharge
- ❑ Genital lesions
- ❑ Painful urination
- ❑ Urgency

METABOLIC
- ❑ Cold intolerance
- ❑ Excessive thirst
- ❑ Excessive hunger
- ❑ Frequent urination
- ❑ Heat intolerance

PSYCHIATRIC
- ❑ Anxiety
- ❑ Depression
- ❑ Insomnia
- ❑ Irritability
- ❑ Nervousness

ALLERGY
- ❑ Itching
- ❑ Hives
- ❑ Chronic runny nose
- ❑ Seasonal allergies

WOMEN ONLY
- ❑ Pregnant
- ❑ Nursing

OTHER:

_____

Patient signature _____Date_____

Reviewed by/MD signature_____

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We appreciate the opportunity to serve you and desire to provide you with the best service possible. The information below is intended to ensure you are aware of certain treatment, financial, and privacy policies. If you have any questions, please inform a member of our front desk staff.

CONSENT FOR MEDICAL TREATMENT

In consideration of the treatment(s) rendered and to be rendered I hereby authorize the medical provider James S. Linder, M.D., P.C., "Dr. Linder", or any other medical providers authorized by it, to provide such medical services, either regular or emergency, as may be determined by the medical provider to be in my best interests (or the best interests of my dependent if I am signing as a parent/guardian).

CONSENT FOR ELECTRONIC PRESCRIBING

I authorize the physicians, and other appropriate licensed providers of James S. Linder, M.D., P.C. and their healthcare team to submit my prescriptions to my pharmacy using secure e-prescribing software. I further authorize access to my medical history, prescription history and current medications from any and all health care providers.

CONSENT FOR STUDENT PARTICIPATION

I understand that my attending physician and/or other James S. Linder, M.D., P.C. personnel may be accompanied and/or assisted by students in various fields of study related to healthcare, such as nursing, physician assistant, medical students, interns, residents, and other allied health fields, and at various stages in their education. I consent to the presence and/or participation in my treatment by these persons while under the direction or supervision of my physician or other healthcare provider.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

I hereby acknowledge I have been offered and/or received a copy of the Privacy Practices Notice of James S. Linder, M.D., P.C. The practice and its representatives may contact me and leave a voicemail message if necessary unless I completed a *Restriction Form* which has been approved in writing by James S. Linder, M.D., P.C.

CONSENT FOR FINANCIAL RESPONSIBILITY

I hereby assign, transfer and set over to James S. Linder, M.D., P.C. all of my rights, title and interest to medical reimbursement benefits provided by my insurance policy(ies) listed below and/or any other third-party payor responsible for paying for the services rendered by Dr. Linder or related medical providers. Should payment be made directly to me, I agree to immediately endorse such payment to Dr. Linder.

In those cases where payment is not collected at the time of service, I understand that I am responsible for the cost of the medical services rendered and agree to pay any and all amounts not paid by others within sixty (60) days from the date billed unless there are other agreements in writing between me or my insurance company and James S. Linder, M.D., P.C. In the event of any dispute, I agree to pay Dr. Linder's collection costs, up to 33.3%, which will be added to the unpaid balance. Other charges may include bad check charges, court costs, witness expenses and reasonable attorney's fees. You agree, that in order for us to service your account or collect amounts you owe, we and our collection agency may contact you by any telephone number associated with your account, including wireless numbers, which could result in charges to you. We and our collection agency may also contact you by sending texts or emails, using any email address you provide us. Methods of contact may include pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. I understand that a refund will not be issued to me until all visits are paid in full and my account retains a credit balance.

I understand that it is my responsibility to know the requirements of my insurance policy and to comply with them. If Dr. Linder does not participate in my plan, I agree to be responsible for any costs not paid by my insurance company. Furthermore, if my insurance plan does not pay Dr. Linder, for any reason, I agree to be responsible for the costs of my treatment.

I specifically give Dr. Linder the authority to release my medical records to any medical provider who needs access to them to provide appropriate medical care. Furthermore, Dr. Linder may release my medical records to those who perform Dr. Linder's billing services and to any third-party payors who are responsible for my bill. I acknowledge receipt of Dr. Linder's privacy guidelines and have been given the opportunity to object to other listed reasons for release. These authorizations and releases remain in effect until I choose to revoke them by delivering a written statement to James S. Linder, M.D., P.C.

Signature of Patient:_____ **Date:**_____

In the event we cannot contact you, please list any family members or other persons, if any, who we may inform about your general medical conditions and diagnosis and/or appointment information.

Name: _____ **Relationship:** _____ **Phone:** _____

Name: _____ **Relationship:** _____ **Phone:** _____

Name: _____ **Relationship:** _____ **Phone:** _____