41990 Cook St BLDG F #1007 Palm Desert CA, 92211 Tel: 760-610-2677 Fax: 760-610-6101

PATIENT INFORMATION

Date: ___________________

Last Name ______________________________ Middle Initial _____ First Name ________________________

Date of birth: ____ Age _______ Sex ☐M ☐F

Billing Address: ____ City __________________________

State _______ Zip _________ E-mail ____

Social Security # ____

Home Phone ( )___________________________ Cell Phone ( )____________________________

Primary M.D. ____________________________________ Referring M.D. ______________________________

How did you hear about us? ____

Employer: _______________________________________ Work Phone: ________________________________

Spouse Name: __________________________________ Employer: __________________________________

Work Phone ( )____________________________ Cell Phone ( )____________________________

Contact Person in Case of an Emergency (Not Living With You) _____________________________________

Work Phone ( )____________________________ Cell Phone ( )____________________________

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have been given the opportunity to read the NOTICE OF PRIVACY PRACTICES for the offices of Jennifer Hui, M.D., a copy of which is available in the waiting area. I understand that a copy of this notice will be made available to me at my request.

Patient Name: ____ Date: _________________________

I do_____ do not_____ wish to have marketing materials (including appointment reminder cards) mailed to my home address. ____________
Initial

INSURANCE INFORMATION

Primary Insurance: ________________________________ Primary Ins. I.D. no.: _________________________

Group no.: ______________________________________ Union/Local no.: ____________________________

Secondary Insurance: ______________________________ 2ndary Ins. I.D. no.: __________________________

Group no.: ______________________________________ Union/Local no.: ____________________________

I hereby authorize Dr. Hui to release any and all medical information to the above-named carrier (or to designate attorney) for purposes of claims administration, utilization review and financial audit. This authorization remains valid and effective from the date of the signing until revoked in writing. I understand that I may request a copy of this authorization. I have read this authorization and understand it. I hereby assign to Dr. Hui all money in which I am entitled for medical and/or surgical expense related to the service rendered by her, but not to exceed my indebtedness to said physician and/or surgeon. It is understood that any money received from the above named insurance company, over and above my indebtedness, will be refunded to me when my bill is paid in full. As a courtesy, the office will bill my primary insurance carrier for services rendered. I understand that I am financially responsible for remaining balance due, in the event that my secondary insurance carrier does not remit payment to the provider within 30 days of service. Any overpayment will be immediately refunded to me, upon payment receipt from the secondary insurance carrier. I understand I am financially responsible to said doctor for charges not covered by my assignment, or in the event that I do not provide timely or accurate insurance information. I further agree, in the event of non-payment, to bear the cost of collection and/or court cost and reasonable legal fees should this be required.

______________________________________ ____________________________________

INSURED OR GUARDIAN'S SIGNATURE PATIENT'S SIGNATURE

INSURANCE SUBSCRIBER INFORMATION

This information is for the person who is the primary holder of the insurance. For example: Both you and your spouse work, but the insurance is from your spouse's employer. This would then be your spouse's information. AND/OR If the patient is a minor, please complete with the parent/guardian information:

Last Name ______________________________ Middle Initial _____ First Name ________________________

D.O.B. ____ Age _______ Sex ☐M ☐F

Relationship to Patient ____

Address ____

City ____ State ______________ Zip ___________________

Home Phone ( )___________________________ Cell Phone ( )_____________________________

Social Security Number ____ (Required for billing purposes)

Employer ______________________________________ Work Phone ( )____________________________

Address: ____

City ____ State ______________ Zip ___________________

This information is intended only for use by designated individuals. It may contain confidential information protected by local, state, or federal regulations, including HIPAA. Thank you.

THE EYELID INSTITUTE

NAME: ______________________________ AGE: __________ DATE: ____________

CHIEF COMPLAINT: Please write a brief description of your main Eye, Eyelid, Tearing or Orbital condition:
(The reason for your visit today) ____

____

____

Please check (√) any of the following you have:

☐Heart Disease	☐Asthma	☐Stroke	☐High Blood Pressure
☐COPD/Emphysema	☐Kidney Disease	☐Ulcer Disease	☐Hepatitis
☐Diabetes	☐High Cholesterol	☐Bleeding Disorder	☐HIV

OTHERMEDICALPROBLEMS:

1. ____
2. ____

PREVIOUS SURGERIES:

1. ____
2. ____
3. ____

PHARMACY NAME: ______________________ **PHONE**______________________

MEDICATION CURRENTLY TAKING (PLEASE INCLUDE NAME, FREQUENCY, DOSAGE, ROUTE):

1. ____________________	6. ____________________
2. ____________________	7. ____________________
3. ____________________	8. ____________________
4. ____________________	9. ____________________
5. ____________________	10. ____________________

ARE YOU ALLERGIC TO ANY MEDICATIONS: ☐YES If yes, list below ☐NO

1. ____________________	3. ____________________
2. ____________________	4. ____________________

THE EYELID INSTITUTE

SOCIAL HISTORY/HABITS:

Marital Status: (Circle one) ☐Married ☐Divorced ☐Single ☐Widowed

Do you have children? ☐Yes ☐No If yes, how many? ___________________________________

Have you ever used tobacco? ☐Yes ☐No If yes, how many years? _______If you quit, when?______

Do you currently smoke? ☐Yes ☐No If yes, how many packs per day? ____________________

Do you drink alcohol? ☐Yes ☐No If yes, how many drinks per day? ____________________

Family History	Hearing Loss	Cancer	High Blood Pressure	Diabetes	Thyroid Disease	Bleeding Disorder	Heart Disease	Kidney Disease
Patients Father								
Patients Mother								
Patients Father's Parents								
Patients Mother's Parents								
Siblings (brothers/sisters)								
Children								

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HISTORY & REVIEWS OF SYSTEMS:
PLEASE CHECK (√) THE FOLLOWING SYMPTOMS YOU PRESENTLY HAVE:

EARS	X	SYMPTOMS	NOSE	X	SYMPTOMS
DIZZINESS/VERTIGO			RUNNY NOSE		
DECREASED HEARING			POST NASAL DRIP		
EYES	**X**	**SYMPTOMS**	OBSTRUCTION		
LOSS OF VISION/BLURRY			SINUS PAIN/PRESSURE		
EYELID PROBLEMS – SPECIFY			ALLERGIES		
TEARING			LOSS OF SENSE SMELL/TASTE		
THROAT	**X**	**SYMPTOMS**	SLEEP APNEA		
SORE THROAT			SNORING		
VOICE CHANGE			**MOUTH**	**X**	**SYMPTOMS**
FREQUENT CLEARING			DRY MOUTH		
DIFFICULTY SWALLOWING			ULCERS		
CARDIAC (HEART)	**X**	**SYMPTOMS**	**MUSCULAR/SKELETAL**	**X**	**SYMPTOMS**
TIRED WITH EXERCISE			BACK PAIN		
LEG SWELLING			ARTHRITIS/RHEUMATISM		
CHEST PAIN/PRESSURE			MUSCLE PAIN/WEAKNESS		
HEART MURMURS			OSTEOPOROSIS		
HEART PALPITATION			JAW PAIN/POPPING		
NEUROLOGIC	**X**	**SYMPTOMS**	**ENDOCRINE**	**X**	**SYMPTOMS**
HEADACHES			DIABETES		
LIGHT HEADEDNESS			THYROID PROBLEMS		
NERVOUS DISORDERS			GOITER/NODULE		
EPILEPSY/SEIZURES			THYROID MEDICATION		
STROKES			**GASTROINTESTINAL**	**X**	**SYMPTOMS**
PULMONARY (LUNG)	**X**	**SYMPTOMS**	WEIGHT LOSS		
SHORTNESS OF BREATH			JAUNDICE		
CHRONIC COUGH			ABDOMINAL PAIN		
COUGHING UP BLOOD			ULCER		
ASTHMA			HEARTBURN/REFLUX		
EMPHYSEMA					

EXPLANATION: ____

____

____

____

____

THE EYELID INSTITUTE

PATIENT CONSENT FOR MEDICAL PHOTOGRAPHY

CONSENTIMIENTO DEL PACIENTE PARA FOTOGRAFIA MEDICA

Patient Name: ____ _______ Date: ___________________________
(Nombre) *(Fecha)*

I consent for medical photographs to be made of me or my child (or person for whom I am legal guardian). I understand that the information may be used in my medical record. By consenting to these medical photographs, I understand that I will not receive payment from any party. Refusal to consent to photographs will in no way affect the medical care I will receive.

Doy mi consentimiento para fotografías médicas se hagan de mí o mi hijo (o la persona por quien yo soy tutor legal). Entiendo que la información puede ser utilizada en mi expediente médico. De acuerdo con estas fotografías médicas, entiendo que no recibiré pago de cualquier partido. La negativa a dar su consentimiento a las fotografías de ninguna manera afectar la atención médica que va a recibir.

______________________ Signature*(Firma)* _____________________________ Witness

For patients between ages 7 and 18, a signature below indicates that the information in this consent form has been explained to me, and I attest the use of my images as outlined above:

Para los pacientes entre las edades de 7 y 18 años, una firma a continuación indica que la información de este formulario de consentimiento se ha explicado a mí, y doy fe de la utilización de mis imágenes como se describe más arriba:

______________________ Signature of Patient _____________________________ Witness
(Firma de Paciente)

NO SHOW AND APPOINTMENT CANCELLATION & LATE POLICY

CANCELACIÓN SIN MOSTRAR Y NOMBRAMIENTO Y POLÍTICA DE TARDE

Patients who fail to show for their appointments and who do not notify the practice in advance, are costly to the practice and may prevent a sick individual who needs to be seen from getting a preferred appointment time. For the purposes of this policy, a no-show appointment is defined as an appointment, which is missed by the patient without notifying the practice, or an appointment that is cancelled by the patient within 24 hours of their scheduled appointment time. If you cannot make your appointment, PLEASE CANCEL YOUR APPOINTMENT AS SOON AS POSSIBLE, SO IT CAN BE MADE AVAILABLE FOR ANOTHER PATIENT! Patients who no-show or fail to cancel their appointment 24-hours prior the scheduled time, will be charged a $35 fee.

Los pacientes que no muestran por sus nombramientos y que no notifica a la práctica con antelación, son costosos para la práctica y puede impedir que una persona enferma que necesita ser vista de conseguir una cita preferida. Para los propósitos de esta política, una cita no se presenta se define como una cita, que se pierde por el paciente sin notificar a la práctica, o una cita que se cancela por el paciente dentro de las 24 horas siguientes a su cita. Si usted no puede asistir a su cita, por favor cancele su cita a la brevedad posible, para que puedan estar disponibles para otro paciente! Los pacientes que no se presenta o no cancela su cita 24 horas antes de la hora programada, se le cobrará una cuota de $ 35.

Patients who arrive late for their appointments cause significant disturbance to the planned schedule. One or two late patients can cause other patients to wait for over one hour. Please be respectful to other patients and to the office staff. Patients arriving on time will be given priority. Any patient arriving more than 15 minutes late for their appointment may have to wait to be seen. Late patients may also be given the option of rescheduling their appointment.

Los pacientes que llegan tarde a sus citas causar perturbación significativa al calendario previsto. Uno o dos pacientes inasistentes pueden causar otros pacientes que esperar más de una hora. Por favor, sea respetuoso con los demás pacientes y para el personal de oficina. Los pacientes que llegan a tiempo se les dará prioridad. Cualquier paciente que llega más de 15 minutos tarde a su cita puede tener que esperar a la vista. Pacientes atrasados también pueden tener la opción de reprogramar su cita.

I acknowledge that I have been informed of these policies and have had adequate opportunity to have any questions answered.

Yo reconozco que he sido informado de estas políticas y han tenido una adecuada oportunidad de tener alguna pregunta contestada.

______________________ Signature*(Firma)* _____________________________ Witness