Adam J. Scheiner, M.D.
Laser Eyelid & Facial Plastic Surgery

Name: _____
Date : _____

New Patient Questionnaire

How did you hear about Dr. Scheiner? _____
What areas or facial features are your most interesting in having Dr. Scheiner evaluate for you today?
_____

Have you had any of these procedures previously? If so, please provide details of type of procedure and/or products used.

( ) eye surgery: _____
( ) eyelid surgery: _____
( ) facial surgery: _____
( ) fillers: _____
( ) Botox: _____
( ) Laser treatments on your face: _____

Do you currently wear contact lenses? ( ) yes ( ) no *If so, do you also have a pair of updated glasses to use when not wearing contact lenses? ( ) yes ( ) no
Do you smoke? ( ) yes ( ) no ( ) in the past

Do you have any history of :

( ) High Blood Pressure ( ) Asthma ( ) Cancer (including skin cancers)
*if so, what kind and when: _____
( ) Diabetes ( ) Stroke ( ) Acne Treatments
*if so, what kind? _____
( ) Kidney disease ( ) Thyroid disease ( ) Cold sores ( ) Double vision
List major surgeries:
( ) Seizures ( ) Liver disease ( ) Heart disorder _____
_____
( ) Keloid scarring ( ) Melasma ( ) Abnormal healing of wounds _____
_____
( ) Psoriasis ( ) Eczema ( ) Vitiligo ( ) Facial Paralysis _____

List of current *medications* and any *supplements (if applicable, please include aspirin, fish oils, vitamin E, and any anti-inflammatory drugs*: _____
_____
_____

Allergies (including LATEX):
_____

Your genetic make-up can tell us a lot about the characteristics of your skin. What is your ethnicity (i.e. Irish, Colombian, African-American, Asian, etc.)? _____
Do you burn easily/"get pink" in the sun when not wearing sunscreen? ( ) yes ( ) no ( ) occasionally

Preferred Pharmacy: _____

Did you know?

*We have solutions for **all** of the concerns listed below! Which ones affect you?*

Please check all that apply:

( ) Age spots/uneven pigmentation
( ) Dry skin
( ) Melasma
( ) Facial skin cancers, sun damage, and wrinkles
( ) Rosacea
( ) Facial moles
( ) Thin lips
( ) Facial veins
( ) Lower eyelid bags/festoons
( ) Urinary Incontinence
( ) Decreased sexual sensitivity
( ) Facial volume loss
( ) "Resting-bitch" face
( ) Frown lines/smile lines
( ) Facial Acne or acne scarring
( ) Droopy skin on face and neck
( ) Aged hands
( ) Double chins
( ) Unwanted hair (any part of the body)
( ) Make-up for sensitive skin
( ) Short/sparse eyelashes
( ) Spider veins
( ) Dry eyes
( ) Don't like your nose? We can help you with that as well!

We will be happy to discuss effective solutions available to you during your consultation with Dr. Scheiner.

TAMPA EYE CLINIC
Founded 1963

Tampa Eye Clinic

PATIENT INFORMATION

~~2017~~ 299

- ☐ Dr. Seeley
- ☐ Dr. Reynolds
- ☐ Dr. Leach
- ☐ Dr. Lorenzen
- ☐ Dr. Scheiner
- ☐ Dr. Orlick
- ☐ Dr. Nogales
- ☐ Dr. Patel
- ☐ Dr. Robinson
- ☐ Dr. Mercer
- ☐ Dr. Revennaugh

PLEASE PRINT CLEARLY

PATIENT NAME:

LAST _____ FIRST _____ MIDDLE _____

MAILING ADDRESS:

_____
STREET / PO#

CITY _____ STATE _____ ZIP _____

_____
E-MAIL ADDRESS

HOME PHONE: _____ **CELL PHONE:** _____

SEX: ☐ FEMALE ☐ MALE

MARITAL STATUS: ☐ MARRIED ☐ SINGLE

DATE OF BIRTH: MONTH _____ DAY _____ YEAR _____

SOCIAL SECURITY #: _____

DRIVERS LICENSE: *Please allow staff to copy to place in your records* _____

CHECK ALL THAT APPLY:

PREFERRED LANGUAGE:

☐ ENGLISH ☐ SPANISH ☐ OTHER _____

ETHNICITY:

☐ HISPANIC / LATINO ☐ NON-HISPANIC / LATINO ☐ REFUSED / DECLINED

RACE;

☐ AFRICAN / AMERICAN ☐ AMERICAN INDIAN / NATIVE ALASKAN ☐ ASIAN ☐ CAUCASIAN

☐ EUROPEAN ☐ NATIVE HAWAIIAN / PACIFIC ISLANDER ☐ MULTI-RACIAL ☐ REFUSED / DECLINED

NAME OF PARENT OR GUARDIAN: *((if applicable)* _____

TELEPHONE NUMBER OF PARENT OR GUARDIAN: *(if applicable)* _____

OCCUPATION:

☐ EMPLOYED ☐ HOMEMAKER ☐ CHILD/STUDENT ☐ RETIRED ☐ DISABLED ☐ OTHER _____

CO. NAME: _____ PHONE: _____

PRIMARY CARE PHYSICIAN: _____ **PHONE:** _____

IS THIS A WORKERS' COMPENSATION VISIT?

☐ YES ☐ NO IF YES, DATE OF ACCIDENT: _____

PLEASE COMPLETE OTHER SIDE ⇨

HOW DID YOU FIND OUT ABOUT THE TAMPA EYE CLINIC? *(please check one)*

❑ INSURANCE CO. ❑ FRIEND/RELATIVE ❑ PHONE BOOK ❑ INTERNET ❑ SIGN ❑ TV/RADIO ❑ EMERGENCY ROOM ❑ EYE SCREENING

❑ MEDICAL DOCTOR *(Name):* _____ ❑ OTHER: *(please specify)* _____

WHOM TO NOTIFY IN AN EMERGENCY? (Nearest relative not living with you)

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____

HOME PHONE: _____ WORK PHONE: _____

PRIMARY INSURANCE INFORMATION:

NAME OF INSURANCE COMPANY: _____

ADDRESS: _____

ACCOUNT #: _____ GROUP #: _____

POLICYHOLDER: _____ RELATIONSHIP TO PATIENT: _____

POLICYHOLDER SS#: _____ POLICYHOLDER DATE OF BIRTH: _____

SECONDARY INSURANCE INFORMATION:

NAME OF INSURANCE COMPANY: _____

ADDRESS: _____

ACCOUNT #: _____ GROUP #: _____

POLICYHOLDER: _____ RELATIONSHIP TO PATIENT: _____

POLICYHOLDER SS#: _____ POLICYHOLDER DATE OF BIRTH: _____

FINANCIAL ASSIGNMENT AND AGREEMENT:

I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished me. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services, its agents, or any insurance carrier information needed to determine these benefits and to secure payment. I understand that I am financially responsible for all charges whether or not paid by said insurance and should I default on my account, all attorney fees, interest, and collection costs are my responsibility.

I also understand that payment is expected at the time services are rendered.

_____ _____

SIGNATURE **DATE**

Medical Information Release Form

(HIPAA Release Form)

Name: _____ Date of Birth: ____/___/____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (*day*)_____ between (*time*)_____

Signed: _____ Date: ____/____/____

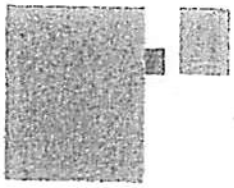
Witness:_____ Date: ___/____/_____

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGMENT:

I hereby acknowledge that I have received and had an opportunity to ask questions concerning Tampa Eye Clinic's Notice of Privacy Practices.

Name of Patient or Patient's Representative	Date
Representative's Relationship to Patient	Signature



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Appointment Cancellation Policy

We strive to render excellent patient care to you and the rest of our patients. In an attempt to be consistent with this, we have an Appointment Cancellation Policy that allows us to schedule appointments for all patients. When an appointment is scheduled, that time has been set-aside for you and when it is missed, that time cannot be used to treat another patient.

Our policy is as follows:

We require that you give our office 48 hours notice in the event that you need to reschedule your appointment. This allows for other patients to be scheduled into that appointment. If you miss an appointment without contacting our office within the required time, this is considered a missed appointment. A fee of $35.00 will be charged to you; this fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments can be scheduled nor can records be transferred with out the payment of this fee.

Additionally, if a patient is more than 20 minutes late without prior notice for a scheduled appointment, we will consider this a missed appointment and the $35.00 cancellation fee will be charged.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have.

I have read and understand the Appointment Cancellation Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

I, _____ (print name), have received a copy of our cancellation policy.

We thank you for your patronage.

Adam J. Scheiner, MD and all Staff Providers

Signature of Patient _____ Date _____