Northwest Eyelid & Orbital Specialists, PS
626 S. Sheridan St., Spokane, WA 99202
(509) 279-2176

PATIENT INFORMATION

Patient Name _____
Last First Middle

Address _____

City _____ State _____ Zip _____ Birthdate _____ Sex _____

Home# _____ Work# _____ Cell# _____

Marital Status _____ SSN _____ Employer _____

Email Address _____

Referring Dr. _____ Primary Dr. _____ Cardiologist _____

GUARANTOR (Person who holds Insurance)

Name _____
Last First Middle

Address _____

City _____ State _____ Zip _____ Birthdate _____ Sex _____

SSN _____ Employer _____ Work# _____

INSURANCE INFORMATION

Primary Insurance _____ Subscriber _____

ID# _____ Group# _____ Copay Amount _____

Secondary Insurance _____ Subscriber _____

ID# _____ Group# _____ Copay Amount _____

****OUR OFFICE DOES NOT ACCEPT CASH.**
ONLY CHECK OR DEBIT/CREDIT CARD ACCEPTED**

I hereby authorize my insurance benefits to be paid directly to the physician. I authorize the physician or the insurance company to release any information required for this claim. I am financially responsible for any balance due and any collections costs should action need to be brought to collect payment.

Signature _____ **Date** _____

Northwest Eyelid & Orbital Specialists, PS
626 S. Sheridan St Spokane, WA 99202
(509) 279-2176

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see a copy of that record. You may also ask us to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Jami Powers, Office Manager & Privacy Officer for the practice.

Our **Notice of Privacy Practice** describes in more detail how your health information may be used or disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practice: This form will be retained in your medical record.

_____ _____

Patient or legally authorized individual signature Date

_____ _____

Print name if signed on behalf of the patient Relationship to patient

In addition to allowable disclosures described in the Statement of Privacy Practice, I hereby specifically authorize disclosure of my protected health information to the persons indicated: (**please specify names below**)

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Northwest Eyelid and Orbital Specialists, P.S.
& NEOS Surgery Center
Kevin Michels, MD and Talmage Broadbent, MD
626 S Sheridan St, Spokane, WA 99202
Telephone: 509-279-2176
Fax: 509-279-2941

PATIENT PHOTOGRAPHIC CONSENT

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, obtain insurance authorization for surgery, for purposes of medical teaching and in medical publications including the office website as I have designated below. By consenting to these medical photographs, I understand that I will not receive payment from any party. However, the provider will bill my medical insurance, or any self-pay one time annually for these photographs. If I have any questions, then I may contact the HIPAA privacy officer (Jami Powers – Administrator) at 509-279-2176.

Please initial one of the following:

_____ All media, internet and educational purposes: I consent for these photographs to be used in my medical record, obtaining insurance authorization for surgery, any medical publications, on the Northwest Eyelid and Orbital Specialists website, for teaching purposes, and for the purpose of informing the general public about treatment and/or surgery methods. Although these photographs will be used WITHOUT identifying my name, I understand that it is possible for someone to recognize me. I release and discharge Northwest Eyelid and Orbital Specialists, P.S. and all parties acting under its license and authority all rights that I may have in the photographs from my claim that I may have relating to such use in publication. These photographs will be charged to my insurance company or any self-pay one time annually and this may apply to deductible or out of pocket expense depending on my insurance plan.

_____ Medical record only: Photographs taken of me at Northwest Eyelid and Orbital Specialists, P.S may only be used for my medical records. This includes purposes of obtaining insurance authorization for surgery if applicable and required by so called insurance company. These photographs will be charged to my insurance company or any self-pay one time annually and this may apply to deductible or out of pocket expense depending on my insurance plan.

By signing the form, I acknowledge my consent and confirm that this form has been explained to me in terms which I understand. I have read and understand the consent and release.

_____ _____
Signature Date

_____ _____
Parent/Legal Guardian (if under 18) Date

Northwest Eyelid & Orbital Specialists, PS
626 S. Sheridan, Spokane, WA 99202

HEALTH SUMMARY SHEET

Patient Name: _____ **Birthdate:** _____

Please list ALL medications, vitamins and/or supplements: (INCLUDING DOSAGE)

_____ _____ _____

_____ _____ _____

_____ _____ _____

Do you take Aspirin – please CIRCLE which regimen:

**ASPIRIN - (REGIMEN BY DOCTOR) **ASPIRIN - (AS NEEDED)

Do you take any of the following: (CIRCLE ALL THAT APPLY – EVEN AS NEEDED)

ADVIL IBUPROFEN MOTRIN ALEVE FISH OIL FLAXSEED
VITAMIN-E BLOOD THINNERS NATUROPATHIC MEDS

Please list allergies to medications and your reaction:

_____ _____ _____

Do you have a history of dizziness, nausea or being sick after anesthesia? Y / N

MEDICAL HISTORY

ASTHMA/COPD/EMPHYSEMA	Y / N	KIDNEY DISEASE	Y / N
HYPERTENSION	Y / N	ARTHRITIS	Y / N
HEART DISEASE	Y / N	SLEEP APNEA	Y / N
PACEMAKER/DEFIBRILLATOR	Y / N	SKIN DISEASE	Y / N
STROKE	Y / N	IRREGULAR SCARRING	Y / N
NEUROLOGIC DISORDER	Y / N	MRSA	Y / N
DEMENTIA/ALZHEIMER'S	Y / N	DIABETES	Y / N
CANCER	Y / N	THYROID DISEASE	Y / N
HYPERCHOLESTEROLEMIA	Y / N	KELOIDS	Y / N
AIDS/HIV	Y / N	DIALYSIS	Y / N
HEPATITIS	Y / N		

Please list all surgeries from BIRTH to PRESENT: (include date)

_____ _____ _____

_____ _____ _____

EYE HISTORY

GLAUCOMA	Y / N	AMBLYOPIA	Y / N
GLAUCOMA SURGERY	Y / N	MACULAR DEGENERATION	Y / N
CATARACTS	Y / N	EYELID SURGERY	Y / N
CATARACT SURGERY (circle) RT - LT	Y / N	OTHER (Please specify):	

***** IF YOU ARE A CONTACT LENS WEARER, PLEASE BRING DISTANCE CORRECTION GLASSES TO APPOINTMENT IF APPLICABLE*****

Patient Signature: _____ **Date:** _____

Northwest Eyelid & Orbital Specialists, PS
626 S Sheridan, Spokane, WA 99202

REVIEW OF SYSTEMS

Patient Name: _____ **Birthdate:** _____

Do you currently have any problems in the following areas? **(If YES, please circle symptom)**	NO	DETAILS/OTHER
GENERAL/CONSTITUTIONAL: Fever, sweats, chills, weight loss, weight gain, fatigue		
EYES: Poor vision, vision loss, eye pain, tearing, redness, drooping of the eyelid, eyelid lesion, eye irritation, eye swelling		
EARS, NOSE, THROAT: Hard of hearing, stuffy nose, earache, cough, sinus congestion, difficulty swallowing, sore throat, dry mouth		
CARDIOVASCULAR: High BP, low BP, palpitations, irregular heartbeat, irregular pulse, high cholesterols		
RESPIRATORY: Chest congestion, wheezing, shortness of breath		
GASTROINTESTINAL: Constipation, diarrhea, GERD, heartburn, hernia, ulcers, jaundice		
GENITAL, KIDNEY, BLADDER: Painful urination, frequent urination, blood in urine, impotence, incontinence		
MUSCLES, BONES, JOINTS: Joint pain, stiffness, swelling, cramps, arthritis		
SKIN: Pimples, warts, growths, skin rashes, eczema, psoriasis		
NEUROLOGICAL: Seizures, numbness, headache, paralysis, depression, anxiety, insomnia		
ENDOCRINE: Diabetes, hypothyroid, hyperthyroid		
BLOOD/LYMPH: History of blood transfusions, bleeding disorder, anemia		
ALLERGIC/IMMUNOLOGIC: Sneezing, hives, itching, Lupus		
FEMALES: Pregnant, Nursing		
OTHER:		

FAMILY HISTORY **Please list pertinent medical history: (Father, Mother, Brother, Sister, Son or Daughter)**	Details: _____ _____ _____ _____

SOCIAL HISTORY

Do you drink alcohol?	YES	NO	If YES, average drinks per day _____, week_____, year _____
Do you smoke?	YES	NO	If YES, packs per day_____ or per week:_____
Have you ever smoked?	YES	NO	How many years and how much did you smoke? _____yrs _____
What is your occupation?			
Marital Status? (Please circle one) Married Single Widowed Divorced			

Patient Signature: _____ **Date:** _____