OCULOFACIAL
PLASTIC SURGERY
of HAWAII

New Patient Registration

Date _____

Name _____

Last First Middle

Date of Birth_____ **Age**_____ **Sex M / F**

Home Address _____

City_____ **State** _____ **Zip**_____

Home Phone (_____)_____ **Work** (_____)_____

Cell Phone (_____)_____ **E-Mail**_____

***How would you prefer we contact you regarding care at our center? (Please circle all that you are comfortable with):*

Email Cell Phone Work Home Phone

Would you allow us to include your email when we send out our newsletters? You can always remove yourself later ***Y or N***

Occupation_____ **Employers Name** _____

Marital Status ____**Minor** _____**Single** _____**Married** ____**Widowed** _____**Divorced** _____**Separated**

Name of Spouse (or parent if Minor)_____ **Phone**_____

Emergency Contact_____ **Relationship**_____ **Phone**_____

Family Doctor_____ **Phone**_____

Ophthalmologist or Optometrist _____ **Phone**_____

Pharmacy & Phone_____

Company Number

How did you hear about us? Google_____ Yelp_____ Realself _____ Other_____

Insurance information

Primary Insurance_____

Secondary Insurance_____

Policy Holder's Name (if different from above) _____**DOB**_____

SSN#_____ **Relationship to Patient**_____

Authorization: I hereby authorize Dr. Bradford Lee to be the attending physician and to administer to me any examination, treatment, and medications he deems therapeutic to my presenting complaint. I hereby authorize Dr. Bradford Lee to furnish information to my insurance carriers concerning this illness and I hereby irrevocably assign to the doctor all payments for medical services.

Signature of Patient/Parent/Guardian: _____ **Date:**_____

Patient History

Patient Name : _____ Date of Birth: _____ / _____ / _____

Height: _____ Weight: _____ Date of Last Dilated Eye Exam: _____

EYES

Yes	No	
□	□	Glasses
□	□	Contacts □ Soft □ Hard
□	□	Glaucoma
□	□	Dry Eye
□	□	Punctal Plugs
□	□	Cataracts
□	□	Strabismus
□	□	Macular Degeneration
□	□	Recent Fillers and/or Botox Location: _____
□	□	Facial Trauma - Type: _____
□	□	Thyroid Eye Disease
□	□	Oculopharyngeal Muscular Dystrophy
□	□	Ocular Cicatricial Pemphigoid (OCP)
□	□	Previous Eye, Eyelid, and / or Tearing Surgery – Type: _____

EARS, NOSE & THROAT

Yes	No	
□	□	Limited Mouth / Neck Motion
□	□	TMJ History
□	□	Dentures
□	□	Ringing in Ears
□	□	Deviated Septum
□	□	Chipped / Loose Teeth
□	□	Chronic Sinus Infections
□	□	Previous Sinus Surgery

ENDOCRINE

Yes	No	
□	□	Diabetes - # of Years: _____ □ Type 1 □ Type 2
□	□	Insulin Dependent
□	□	Non-Insulin
□	□	Diet Controlled
□	□	Hyperthyroid
□	□	Hypothyroid

HEART

Yes	No	
□	□	High Blood Pressure
□	□	Angina
□	□	Chest Pain
□	□	Congestive Heart Failure
□	□	Bypass
□	□	Stents
□	□	Mitral Valve Prolapse
□	□	Heart Murmur
□	□	Arrythmia
□	□	Atrial-fibrillation
□	□	SVT
□	□	Heart Attack
□	□	Pacemaker
□	□	Defibrillator
□	□	Heart Transplant
□	□	High Cholesterol
□	□	Wolff-Parkinson – White Syndrome

BLOOD DISORDERS

Yes	No	
□	□	Anemia
□	□	Sickle Cell Anemia
□	□	Hepatitis
□	□	Leukemia
□	□	HIV
□	□	AIDS
□	□	Factor 5 Deficiency

NEURO / PSYCHIATRIC

Yes	No	
□	□	Stroke
□	□	Fainting Spells
□	□	Numbness
□	□	Myasthenia Gravis
□	□	Seizures
□	□	Bell's Palsy
□	□	Facial Paralysis
□	□	Headaches
□	□	Migraines
□	□	Depression
□	□	Anxiety

SKIN CONDITIONS

Yes	No	
□	□	Skin Cancer Type & Location: _____
□	□	Rosacea
□	□	Eczema
□	□	Psoriasis

RENAL

Yes	No	
□	□	Bladder Disease
□	□	Kidney Disease
□	□	Kidney Stones
□	□	Dialysis
□	□	Kidney Removal

STOMACH

Yes	No	
□	□	Hiatal Hernia
□	□	GERD
□	□	Diverticulitis
□	□	Ulcers

MUSCULOSKELETAL

Yes	No	
□	□	Back Pain
□	□	Arthritis
□	□	Trauma and / or Surgery to Neck or Shoulder – Type: _____

RESPIRATORY SYSTEM

Yes	No	
□	□	Asthma
□	□	Bronchitis
□	□	COPD
□	□	Emphysema
□	□	Sleep Apnea
□	□	CPAP
□	□	Sarcoidosis

MEDICATION LIST

_____ _____ _____

_____ _____ _____

ALLERGIES

□ Egg □ Latex □ Betadine □ Penicillin □ Sulfa

Please list any other allergies: _____ _____

_____ _____ _____

SOCIAL HISTORY

Current Smoker □ Yes □ No If yes, how long: _____ How much: _____

Previous Smoker □ Yes □ No If yes, how long: _____ Date quit: _____

Alcohol □ Yes □ No If yes, frequency: _____

Drug Use □ Yes □ No If yes, type: _____

Occupation: _____

PREVIOUS SURGERIES

_____ _____ _____

_____ _____ _____

_____ _____ _____

Any problems with anesthesia in the past? □ Yes □ No If yes, what: _____

Any personal history of cancer? □ Yes □ No If yes, what type: _____

FAMILY HISTORY

□ Thyroid Disease □ Heart Disease □ Diabetes □ Cancer □ Skin Cancer

CURRENT SYMPTOMS OR PROBLEMS YOU ARE HAVING

Yes	No		Yes	No		Yes	No	
□	□	Fatigue	□	□	Rapid Heart Beat	□	□	Facial Spasms
□	□	Fever	□	□	Irregular Heart Beat	□	□	Weakness
□	□	Night Sweats	□	□	Shortness of Breath	□	□	Paralysis
□	□	Increased Sweating	□	□	Wheezing	□	□	Numbness
□	□	Difficulty Sleeping	□	□	Cough	□	□	Tremor
□	□	Diplopia	□	□	Nausea	□	□	Vertigo
□	□	Blurred Vision	□	□	Vomiting	□	□	Headaches
□	□	Eye Pain	□	□	Jaundice	□	□	Bruising Tendency
□	□	Dry Eye	□	□	Reflux / Heartburn	□	□	Bleeding Tendency
□	□	Eyelid Drooping	□	□	Blood in Urine	□	□	Anticoagulant Therapy - (Blood Thinners)
□	□	Visual Impairment	□	□	Difficulty with Urination			
□	□	Excessive Tearing	□	□	Increased Urination	□	□	Weight Loss
□	□	Itching of Eyes	□	□	Skin Rash	□	□	Weight Gain
□	□	Hearing Loss	□	□	Skin Lesion	□	□	Heat and/or Cold Intolerance
□	□	Difficulty Swallowing	□	□	Hives or Eczema	□	□	Increased Thirst
□	□	Ringing in Ear	□	□	Joint Pain	□	□	Depression
□	□	Sinus Pressure	□	□	Joint Swelling	□	□	Anxiety
□	□	Runny Nose	□	□	Back Pain	□	□	Mood Swings
□	□	Chest Pain	□	□	Seizure	□	□	Stress
□	□	Palpitations	□	□	Dizziness			

Completed by: □ Patient □ Family Member (Read and Reviewed with the Patient)

Patient Signature: _____ Date: _____

Authorization for Disclosure of Treatment

I understand that Oculofacial Plastic Surgery of Hawaii maintains my personal records, medical history, symptoms, examinations, and test results as a part of my healthcare. This information is not to be given to any other person without my permission. Therefore, this is a written consent to authorize release of my medical information.

Release of Information

I authorize the release of information including the diagnosis, laboratory values, prescribed medications, treatment plan, examination rendered and claim information. This information may be released to:

Name: _____ Phone: _____
Name: _____ Phone: _____
Name: _____ Phone: _____
Name: _____ Phone: _____

Please check if Information is NOT to be released to anyone _____

Please check if okay to leave detailed information on voicemail _____

Patient Signature: _____ **Date:** _____

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CONSENT FOR PHOTOGRAPHY

I authorize Dr. Bradford Lee and Oculofacial Plastic Surgery of Hawaii, Inc. to take photographs, audio recordings and/or video recordings of me/(my child) for the purposes of medical documentation, insurance authorizations, and as part of my clinical care by Dr. Lee, his staff and associates, and other consulting physicians involved in my care.

Patient Initials: Yes___ No___

Dr. Lee is involved in teaching other physicians, patient education, research, and practice marketing activities for which before and after photos, procedural videos, and associated clinical case information can be invaluable. I authorize Oculofacial Plastic Surgery of Hawaii, Inc. and Dr. Lee to use my medical records, include eyelid and/or full face photographs, videos, and clinical information for use in:

Patient Initials: Yes___ No___ Medical training, teaching, scientific meetings, and medical journals or books

Patient Initials: Yes___ No___ Publications of any media format, including magazines, online internet media, broadcast, social media (e.g. Facebook, Instagram, Twitter, YouTube), websites, or for other promotional, advertising, or commercial purposes.

I hereby grant and release all claims, rights, and interests that I might have in such photography or audio or video recordings or use thereof. I agree that Oculofacial Plastic Surgery of Hawaii, Inc. and its employees will not be responsible for any claims arising in any way out of the taking and use as described above of such photographs, recordings, and case histories. I understand that I will not have an opportunity to inspect and approve such photographs or recordings prior to their use, and that Oculofacial Plastic Surgery of Hawaii, Inc. will be the owner of such photographs and/or recordings.

PATIENT/PARENT/GUARDIAN NAME (PRINTED):_____ DATE:_____

PATIENT/PARENT/GUARDIAN SIGNATURE: _____

WITNESS NAME (PRINTED):_____ DATE:_____

WITNESS SIGNATURE: _____

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Notice of Privacy Practices Acknowledgment

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to my privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly .
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments and physicians certifications

I acknowledge that I can request and review your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at anytime at the address above to obtain the current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____ **Date:** _____