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**_____

*** Would you like to subscribe to our monthly promotions e-newsletter? Y or N ***

Occupation_____ **Employers Name** _____

Marital Status: Single_____ **Married**_____ **Widowed**_____ **Divorced**_____ **Separated**_____

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

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

Family Doctor_____ **Phone**_____

Ophthalmologist or Optometrist _____ **Phone**_____

Cardiologist _____**Phone**_____

Pharmacy & Phone_____

Company Phone

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:**_____

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Phone: 808.888.9981 | Fax: 808.468.4753

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			

Are you up to date on these vaccines? ___ Influenza ___ Pneumonia ___ Other: _____

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 photographs, videos, and clinical information for use in:

Please circle which we may use: **Full face photos** and/or **Cropped photos of eyes only**

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:** _____

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Financial Policy

Insurance
Our office participates with most insurance plans including Medicare. Our staff can provide assistance and limited information for each individual insurance. Please contact your insurance provider regarding specific information and benefits. We require a copy of your updated insurance card and a valid ID at the time of your appointment. Certain insurance companies require a referral from your primary care provider. Please contact your PCP's office if you require a referral, prior to each service rendered.

Cosmetic
There is a $150 non-refundable cosmetic consultation fee. This fee covers a full consultation with Dr. Bradford Lee, and a meeting with the surgical coordinator who will provide detailed information on surgical options/ quotes and information regarding pre/ post operative instructions. This fee applies to both in-person and telemedicine consultations. If a procedure is scheduled with Dr. Lee, this fee is subtracted from the cost of the procedure.

Surgery Fees
We perform surgical procedures in our Ambulatory Surgical Center (ASC) or in a Procedure Room in our office. When surgery is preformed at the ASC, there is a claim submitted to your insurance for both the surgeon's fee, the facility fee, and the anesthesiology fee. When surgery is performed in our office Procedure room there is a procedure room fee but no fee for anesthesia. For cosmetic surgeries a 20% deposit is collected at the time of scheduling, and the remaining balance is due 2 weeks prior to your scheduled surgery date. If a refund is being requested, a 2.5% fee will be deducted from your deposit.

Payment
Payment is expected at the time of services rendered for the patients' portion of the insurance payment (copayments, deductible, co-insurance, etc.) We accept cash, check, or credit card. Returned checks are subject to a $25 service fee.

Cancellation Policy
Please call our office if you cannot make it to your appointment/ surgery. We may charge a 150 cancellation fee if your appointment is not cancelled at least 24 hours prior to your appointment. We may may not offer a refund if your surgery is cancelled within 2 weeks of your scheduled surgery date.

PATIENT FINANCIAL OBLIGATION AGREEMENT:
I understand that all applicable copayments, deductibles, cosmetic fees are due at the time of service. I agree to be financially responsible and provide payment for charges not covered by my insurance company. I authorize my insurance benefits to be paid directly to Oculofacial Plastic Surgery of Hawaii Inc. for services rendered. I authorize representatives of Oculofacial Plastic Surgery of Hawaii Inc. to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim.

FINANCIAL POLICY/ NOTICE OF PRIVACY PRACTICES:
I acknowledge that I was provided a copy of the Oculofacial Plastic Surgery of Hawaii Inc. Financial Policy and Notice of Privacy Practices.

BY SIGNING BELOW, I ACKNOWLEDGE I HAVE READ, UNDERSTAND, AND AGREE WITH THE FINANCIAL POLICY, AND NOTICE OF PRIVACY PRACTICES.

Patient Name: _____

Relationship to Patient: _____

Signature: _____ Date: _____

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