Oculofacial Plastic Surgery
P. Emmett Hurley MD,MS
5800 Main St Williamsville, NY 14221
Ph: (716) 932-7670 Fax: (716) 276-9711
plasticeyedr.com

PATIENT REGISTRATION

Appointment Date: _____

If your appointment is more than 10 days from today, please mail the completed forms to our above address. Otherwise, bring these completed forms to your appointment.

Last Name _____ First Name _____ MI _____
☐ Male ☐ Female ☐ Other

Date of Birth _____ Social Security # _____

Street Address _____

City _____ State _____ Zip _____

Home Phone _____ Mobile Phone _____ Consent to text (circle): Yes or No

Work Phone _____ Email _____
(providing your email will give you access to your online health records, secure messaging with the doctor, and appointment reminders)
Preferred method of contact ☐ Home ☐ Work ☐ Mail ☐ Email ☐ Mobile

Preferred Language ☐ English ☐ Other _____

Race ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian ☐ White ☐ Other _____

Ethnicity ☐ **Hispanic or Latino** ☐ **NOT Hispanic or Latino** ☐ **Unknown**

Marital Status: ☐ **Single** ☐ **Married** ☐ **Widow** ☐ **Divorced**

Emergency Contact Name _____ Relationship _____ Phone _____

Employer's Name _____ **Phone** _____

Address _____ Occupation _____

Primary Insurance _____ **Primary Insurance ID#** _____

Relation to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other
DOB of Subscriber_____

Secondary Insurance _____ Secondary Insurance ID# _____

Relation to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other
DOB of Subscriber_____

How did you hear about us (include your referring doctor)? _____

Family Doctor's Name _____

Address _____ **Phone** _____

Pharmacy Name _____

Address _____ **Phone** _____

PLEASE FILL OUT BOTH SIDES

Print Your Name _____ **Date of Birth** _____

Insurance Authorization:
I the undersigned give my authorization to treat and assign directly to Oculofacial Plastic Surgery of WNY all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am ultimately financially responsible for all approved and covered charges whether or not paid by insurance. For a high deductible healthcare plan, I agree to make a prepayment of $150 & additional for procedures. For an out of network insurance, I agree to make a prepayment of $200 & additional for procedures. I am aware that the difference of the prepayment and the final cost will be expected upon receipt of the bill. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____
Patient Signature Date

Financial Policy Acknowledgement:
I acknowledge I am aware that if I fail to appear for my scheduled appointment I will be charged a fee of $50.00 unless I cancel the appointment with at least 24 hours notice. I understand that payment of non-covered services, co-pays and deductibles are expected at the time of service.

_____ _____
Patient Signature Date

HIPAA Acknowledgement:
I acknowledge receipts of the Practice's Notice of Privacy Practices. I authorize the Practice to use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me and conducting healthcare operations.
I permit a copy of this authorization to be used in place of the original.

_____ _____
Patient Signature Date

Medication History Consent:
I understand that my medication history may be obtained utilizing an electronic information exchange and that this protected health information may provide valuable information for my healthcare provider.
I hereby authorize Oculofacial Plastic Surgery of WNY to access my medication history without limitation or exclusion as is required and/or reasonably advisable to disclose, process, retrieve, transmit, and view for the purpose of the transmission of an electronic prescription issued by a provider authorized by law to prescribe, as necessary for my care and treatment.

_____ _____
Patient Signature Date

Authorization for Oculofacial Plastic Surgery of WNY to Disclose My Health Information:
Oculofacial Plastic Surgery of WNY may use or disclose my health care information to the below individuals such as family and/or friends (You do not need to list your doctors):

Name:_____Phone:_____

Name:_____Phone:_____

Name:_____Phone:_____

II. MyRights: This authorization has no expiration date. I may revoke this authorization at any time, in writing, sent to Oculofacial Plastic Surgery. Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it. I am aware that I can request a copy of this authorization after I have signed it.

_____ _____
Patient Signature Date

PAST MEDICAL HISTORY

Name _____ Today's Date _____

Any ALLERGIES to MEDICATIONS? (Circle): Yes or No Please list & what reaction:

1._____ 2. _____

3._____ 4. _____

List any MEDICATIONS you take now. Include all non-prescription drugs & vitamins

Name of medicine	Strength	How many?	Times a day?	Reason for taking
1.				
2.				
3.				
4.				
5.				
6.				
7.				

MEDICAL HISTORY Do you have any of the following?
Explain any checked items

☐ Autoimmune (lupus etc) _____

☐ Blood/lymph (anemia etc) _____

☐ Cancer _____

☐ Ears/nose/throat _____

☐ Endocrine (**diabetes**, hypothyroid, hyperthyroid, Grave's Disease, etc) _____

☐ Gastrointestinal (Crohns, ulcerative colitis, etc) _____

☐ Heart (high or low blood pressure, high cholesterol, etc) _____

PLEASE FILL OUT BOTH SIDES

MEDICAL HISTORY (CONTINUED) Do you have any of the following?

Explain any checked items

☐ Muscles, Bones, Joints (osteoporosis, arthritis etc) _____

☐ Neurological (stroke, multiple sclerosis) _____

☐ Psychiatric (anxiety, depression, etc) _____

☐ Respiratory (asthma, emphysema, COPD, etc) _____

☐ Skin (eczema, rosacea, psoriasis etc) _____

SOCIAL HISTORY

Do you drink alcohol? ☐ No ☐ Occasional ☐ 1 per day ☐ 2-3 per day ☐ 4+ per day

Do you smoke? ☐ Never ☐ Former Smoker ☐ Current Every Day Smoker ☐ Current Some Day Smoker

If previous, when? _____ years ago

EYE HISTORY Check below and explain (which eye, when it started or estimated surgery date):

☐ Cataract Surgery _____

☐ Eyelid Surgery _____

☐ Glaucoma _____

☐ Macular Degeneration _____

☐ Other Eye Surgeries? _____

SURGICAL HISTORY

Any other major surgeries? (Circle): Yes or No If Yes, Please list:

1._____ 2. _____

3._____ 4. _____

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Welcome to Dr Hurley's office &

thank you for choosing us!

Please be sure to complete the new patient paperwork (**both sides**). If your appointment is more than 10 days from today, please mail the completed forms to our above address. Otherwise, bring these completed forms to your appointment.

Please visit our website at plasticeyedr.com to register for our portal. Using our portal will give you access to your medical records, lab results, secure messaging, payment information and more.

We understand how valuable your time is and for that reason we ask that you fill out your medical history in detail before your appointment. This way we can enter your information into the electronic medical prior to your appointment, which will decrease your wait time:

** **PLEASE LIST ALL OF YOUR MEDICATIONS & WHY YOU TAKE THEM**

** **LIST *ANY* PRIOR SURGERIES & CURRENT HEALTH ISSUES**

** **LIST *ALL* ALLERGIES & YOUR REACTION**

* **Bring your insurance card(s) and photo ID.**

* **Please have your medical records faxed to us from your referring and/or eye doctor.**

* **If you had any orbital imaging (CT or MRI), please bring a copy of the CD to the office PRIOR to your appointment.**

INSURANCE

- Your specialty copay is due at the time of your appointment.
- If you have a deductible plan, $150 is due at the time of your appointment and then we will bill you for the remaining. We will collect additional for any procedures.
- It is the patient's responsibility to inform our office of any changes in insurance coverage.
- All patients will be asked to present their current insurance card at each appointment. Failure to have your card could delay your appointment.

PAYMENTS

- Patients are responsible for co-pays and deductibles at time of service.
- We accept cash, MasterCard, Visa, American Express, Discover, Care Credit & personal checks (under $200) payable to Dr Hurley.

Please feel free to call us with any questions or concerns at 716-932-7670.