FARAMARZ HIDAJI, M.D.

COSMETIC EYELID SURGERY : PEDIATRIC EYE PROCEDURES

PATIENT INFORMATION

Last Name:_____ **First Name:** _____ **Middle Initial:** _____

Date of Birth: _____ **SSN:** _____ **Gender:** M F

Street Address: _____ **Apt number:** _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work:** _____ **Cell:** _____

Please indicate which contact number is preferred: _____ Home _____ Work _____ Cell

Email Address:_____

Employer:_____ **Occupation:**_____

PREFERRED LANGUAGE: _____ English _____ Spanish _____ Other _____

MARITAL STATUS: _____ Single _____ Married _____ Widowed _____ Divorced _____ Other

PARENT/ LEGAL GUARDIAN/ RESPONSIBLE PARTY INFORMATION

Last Name:_____ **First Name:** _____ **Middle Initial:** _____

Date of Birth: _____ **SSN:** _____ **Relation to Patient:** _____

Employment: _____ Full time _____ Part time _____ Retired _____ Not Employed _____ Not Applicable

Occupation: _____ **Employer:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Preferred Phone Number: _____ **Alternate Phone Number:** _____

REFERRING PHYSICIAN INFORMATION

Last Name: _____ **First Name:** _____

Address: _____ **Phone Number:** _____

EMERGENCY CONTACT/MINOR CONSENT

Last Name: _____ **First Name:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone Number: _____ **Relation patient:** _____

May we discuss our patients' medical records with this person? _____ Yes _____ No

Please provide the names of any other individuals with whom we may discuss medical records:

Name: _____ **Relation to Patient:** _____

Name: _____ **Relation to Patient:** _____

List anyone other than a parent or legal guardian that may bring the patient to his/her appointments:

Name: _____ **Relation to Patient:** _____

Name: _____ **Relation to Patient:** _____

ENTER INSURANCE INFORMATION ON THE BACK

PRIMARY INSURANCE: **ID: _____ Group number: _____**

_____

Policy Holder's Last Name: _____ First: _____

Date of Birth: _____ SSN: _____

Relation to Patient: _____ Self _____ Child _____ Spouse _____ Other _____

SECONDARY INSURANCE: **ID: _____ Group number: _____**

_____

Policy Holder's Last Name: _____ First: _____

Date of Birth: _____ SSN: _____

Relation to Patient: _____ Self _____ Child _____ Spouse _____ Other _____

Faramarz Hidaji, M.D.

Cosmetic Eyelid Surgery : Pediatric Eye Procedures

Patient Name:_____ Date of Birth:_____

Medical History:

Have you had any of the conditions below? (Please check all that apply)

___ Allergies	___ Developmental Delay	___ Premature Birth
___ Arthritis	___ Diabetes	___ Seizures
___ Asthma	___ Hearing Loss	___ Sinusitis
___ Attention Deficit	___ Heart Disease	___ Stroke
___ Cancer	___ High Blood Pressure	___ Other

Height:_____ Weight:_____

Please List All Surgical Procedures and the Date: _____
_____
_____

Pharmacy Name & Phone #:_____

Do you take medications on a regular basis? Yes ___ No ___

If yes, please list *(e.g. blood thinners, supplements, etc):* _____
_____
_____

Do you have any allergies? Yes___ No___

If yes, please list *(e.g. food, drugs, latex, etc):* _____
_____
_____

Family History:

Do you have family members with any of the following? (Please check all that apply)

___ Crossed eye/Lazy Eye	___ Glaucoma	___ Benign or Malignant Tumor
___ Cataracts of childhood	___ Diabetes	___ Heart Disease
___ Blindness	___ Droopy Eyelid(s)	

___ *Family History is Unknown*

Social History*:*

Do you drink alcoholic? Yes____ No____ Please circle one: Daily Moderately Occasionally Rarely

Do you smoke? Yes___ No___ If yes, how many daily: _____

Reason for visit:_____

Patient Signature: _____ Date:_____

(Parent or Legal Guardian if patient is a minor)

FARAMARZ HIDAJI, M.D.
COSMETIC EYELID SURGERY : PEDIATRIC EYE PROCEDURES

INFORMED CONSENT

Patient:_____ Date of Birth:_____

I hereby give consent for treatment to Faramarz Hidaji, M.D.

I hereby authorize Faramarz Hidaji, M.D. to leave messages regarding my care or my child's care at my residence; as well as to leave messages at my alternate phone numbers or email address provided.

HIPAA acknowledgement: I acknowledge that I have received/been offered/or can ask for a copy of this office's Notice of Privacy Practices.

I acknowledge that in order for Faramarz Hidaji, M.D. to file an insurance claim on my behalf that I must supply my medical insurance card at the time of service.

I authorize the release of any medical/other information necessary for insurance claims. I authorize assignment of benefits to Faramarz Hidaji, M.D.

Most Medical Plans do not cover the cost of Refractions (process of measuring the eyes for corrective eyeglasses), the fee for a Refraction is $50.00. If you do not want your glasses prescription checked at this visit, please let us know, and that portion of the exam will be omitted.

We do not participate with vision plans and can't bill your insurance for routine exams in most cases; if you choose to have a routine exam with Faramarz Hidaji, M.D. your out-of-pocket cost will be $190, paid at the time of your visit.

I acknowledge that if my account is placed with a Collection Agency, a collection-fee may be added to my account and shall become a part of the Total Amount Due. I will be responsible for any and all cost of collection including attorney fees and court cost. I agree, that in order for you to service my account or to collect any amounts I may owe, Faramarz Hidaji, M.D. and our collection agencies may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. Faramarz Hidaji, M.D. and our collection agencies may also contact me by sending text messages or emails, using any email address I provide to use. Methods of contacting me may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

I have read, understand and approve all of the above.

Patient Signature:_____ Date:_____

(Parent or legal guardian if patient is a minor)