PATIENT INFORMATION

Jeffrey Joseph, M.D.

Name ____DOB______________ Gender: M / F

Address ____City ___________State___ Zip ________

Cell Phone _____________________________ Home Phone __________________________________

Email ____

Employer _________________________________Work Phone _________________________________

How were you referred? ____

Primary Care Physician __________________________________Phone ________________________

Ophthalmologist________________________________Optometrist____________________________

Financial Responsibility (If other than patient)

Name _____________________________________DOB______________ Relationship _____________

Address ____City ___________State___ Zip ________

Cell Phone _____________________________ Home Phone __________________________________

Email ____

Payment Obligations

I hereby assign and authorize direct payment to Jeffrey Joseph, M.D., a Medical Corporation (the Practice), of all benefits due me from my insurance company for services rendered. I agree, whether I sign as the guarantor or as the patient, to pay all sums due to the Practice in consideration of services provided to the patient, at the usual and customary charges of the Practice to the extend allowed by the contract between the Practice and my insurance company. Should the account be referred to an attorney or collection agency for collection, the undersigned shall pay actual attorneys' fees, collection expenses, and interest. Failure of the insurance company to make payment shall not relieve me of my obligation to pay the Practice.

Name____
(Please Print)

Signature ____ Date _______________

Jeffrey Joseph, MD
180 Newport Center Drive, Suite 158
Newport Beach, CA. 92660
949.424.3524

Acknowledgement of Receipt of Notice of Privacy Practices

Signature: _________________________________ Date: ________________________

Print Name: _______________________________ Telephone: ____________________

If not signed by Patient, please indicate who signed:

□ **Parent or Guardian of minor Patient**
□ **Guardian or Conservator of an incompetent Patient**
□ **Beneficiary or personal representative of deceased Patient**

Name of Patient: ____

Confidential Contact Information

If it becomes necessary to contact you by phone, do we have your permission to leave messages regarding lab results and/or appointments on your answering service?

YES ___________ NO ___________

Where do you prefer to receive phone calls? _____ HOME _____ WORK _____ CELL

Name and Telephone Number of an emergency contact that does not live with you:

Name: _________________________ Relationship: ______________ Phone #: ___________

Name and phone # of a person to whom we can disclose your confidential health information

☐ Check if same as above

Name: _________________________ Relationship: ______________ Phone #: ___________

Signature: ____

Jeffrey Joseph M.D.
Ophthalmic Plastic and Reconstructive Surgery

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Patient Photographic Authorization

I consent to photography of parts of my body undergoing treatment for the purpose of pre-operative, intra-operative, and post-operative medical documentation. I authorize Dr. Joseph or his designated assistants to photograph me for the above purpose.

I understand that such photographs shall become the property of the doctor's practice. I authorize Dr. Joseph to use these photographic images for educational purposes including patient education, physician education, scientific presentations, and scientific publications. I understand this may include educational lectures, educational brochures, medical journals, and medical books.

I understand that I will not be identified by name when my photographic images are shown. I reserve the right to view these photographic images and to obtain copies of them for a reasonable fee reflecting the cost of duplication. This consent is valid indefinitely unless revoked in writing.

I hereby grant Dr. Joseph permission to use my photographs on his publicly accessible website:

Where my likeness may be recognizable ___ **Initial**

Only if I am made to look unrecognizable___ **Initial**

____
Patient's Name

____
Patient's Signature

____
Witness's signature

____
Date

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TODAY'S DATE ________________

CLINICAL HISTORY FORM – Part 1

First Name: ___________________________ Middle: _________________ Last: ___________________
Date of Birth: ______________________ Age: __________ Height: ___________ Weight: __________
Preferred Pharmacy: ________________________ City: ________________ Cross Street: ____________
Email address: ____

CHIEF COMPLAINT

Reason(s) for Visit:

1. ____
2. ____

Location(s): ____ **Historian:** _____________________

Onset: ☐ ____ days ☐ ______weeks ☐ ______months ☐ ______years
Duration: ☐ 15 mins. ☐ 30 mins. ☐ 1 hr. ☐ 2 hrs. ☐ Variable_________________
Frequency ☐Intermittent ☐Occasional ☐Constant ☐Random
Status: ☐ improving ☐ unchanged ☐ worsening ☐resolved
Severe of Symptoms: ☐ mild ☐ moderate ☐severe ☐incapacitating

Comments:
____

ALLERGIES: ____ ☐ NO ALLERGIES

OCULAR HISTORY ☐ NONE

☐ Anophthalmia (lost an eye)	☐ Right	☐ Left
☐ Ambloyopia (lazy eye)	☐ Right	☐ Left
☐ ARMD (macular degeneration)	☐ Right	☐ Left
☐ Cataracts	☐ Right	☐ Left
☐ Glaucoma	☐ Right	☐ Left
☐ Graves' Thyroid Eye Disease	☐ Right	☐ Left
☐ Retinal Detachment	☐ Right	☐ Left
☐ Strabismus (crossed eye)	☐ Right	☐ Left

MEDICATIONS (List any medications you are currently taking) ☐ NO MEDICATION

Drug Name	Dosage	Frequency	Status: Chronic, Acute, Discontinued

Name ______________________________ DOB __________ TODAY'S DATE__________

PAST MEDICAL HISTORY (Please check all that apply) ☐ None

☐ Allergies
☐ Anemia
☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Bleeding Disorder
☐ Cancer
☐ Congestive Heart Failure
☐ COPD
☐ Coronary artery disease
☐ Depression
☐ Diabetes
☐ Emphysema
☐ GERD
☐ Grave's disease
☐ Headaches
☐ High Cholesterol
☐ Hypertension
☐ Hyperthyroidism
☐ Hypothyroidism
☐ Intestinal disorder
☐ Irregular heart rate
☐ Kidney disorder
☐ Migraines
☐ Multinodular goiter
☐ Otosclerosis
☐ Seizure disorder
☐ Sinus DX
☐ Sleep Apnea
☐ Speech disorder
☐ Stomach ulcer
☐ Stroke
☐ Tinnitus
☐ Vertigo
Other: ______________

SURGICAL HISTORY ☐ None

Please check all that apply and list year	Date		Date		Date
☐ Angioplasty	________	☐ Colectomy	________	☐ Pacemaker	________
☐ Angioplasty with stent	________	☐ Colostomy	________	☐ Septoplasty	________
☐ Appendectomy	________	☐ Ear Surgery	________	☐ Sinus Surgery	________
☐ Arthroscopy knee	________	☐ Gastric bypass	________	☐ Thyroidectomy	________
☐ Back surgery	________	☐ Hernia repair	________	☐ Tonsillectomy	________
☐ Carpal tunnel release	________	☐ Hip replacement	________	☐ Throat Surgery	________
☐ Cataract extraction	________	☐ Lasik		Other: ____________	________

FAMILY HISTORY (Please list family history) ☐ None ☐ Adopted

List Family Member: ______________________________

☐ Allergies	☐ CVA	☐ Hyperlipidemia	☐ Seizure disorder
☐ Asthma	☐ Depression	☐ Hypertension	☐ Sickle cell disease
☐ Autoimmune disease	☐ Developmental delay	☐ Migraines	☐ Sleep apnea
☐ CAD	☐ Diabetes	☐ Obesity	☐ Thyroid disorder
☐ Cancer	☐ GERD	☐ Chronic Otitis Media	☐ Other ____________
☐ Cleft lip/palate	☐ Hearing disorder	☐ Otosclerosis	☐ Other ____________
☐ Coronary artery disease	☐ Hematological disorder	☐ Renal disease	

SOCIAL HISTORY (Please check the appropriate boxes and fill the accurate amounts of standard options)

Tobacco Use

☐ Current ☐ Former ☐ None
Packs/day ______________
Years used ______________
Year Quit ______________
Type:
☐ Cigarette ☐ Cigar ☐ Pipe
☐ Chewing ☐ Smokeless
☐ Snuff

Alcohol

☐ Current ☐ Former ☐ None
Type:
☐ Beer ☐ Liquor ☐ Wine
Amount: __________ ☐ Day
☐ Week ☐ Month ☐ Year
☐ Occasional ☐ Social ☐ Rare

If former, year quit: ________

Caffeine

☐ Current ☐ Former ☐ None
Type:
☐ Coffee ☐ Tea ☐ Soda
☐ Other

Number of cups per day (8oz)____

Patient Name: ____

REVIEW OF SYSTEMS (Check only the ones you now have or have had recently)		
Constitutional ☐ chills ☐ night sweats ☐ fatigue ☐ weight gain ☐ fever ☐ weight loss ☐ other:______________________ _____________________________ ☐ ALL NEGATIVE	**Cardiovascular** ☐ chest pain ☐ heart murmur ☐ palpitations ☐ other: __________________ ☐ ALL NEGATIVE	**Metabolic/Endocrine** ☐ cold intolerance ☐ heat intolerance ☐ increased thirst ☐ other: ________________________ ☐ ALL NEGATIVE
HEENT ☐ blurred vision ☐ hoarseness ☐ choking on liquids ☐ mouth ulcers ☐ choking on solids ☐ ear pain ☐ double vision ☐ sore throat ☐ dizziness ☐ ringing in ears ☐ difficulty swallowing ☐ visual changes ☐ drooling ☐ vertigo ☐ ear drainage ☐ hearing loss ☐ other: :_____________________ _____________________________ ☐ ALL NEGATIVE	**Gastrointestinal** ☐ abdominal pain ☐ constipation ☐ diarrhea ☐ heartburn ☐ vomiting ☐ other: _______________ ☐ ALL NEGATIVE	**Neurological** ☐ difficulty falling asleep ☐ syncope ☐ difficulty staying asleep ☐ tingling ☐ excessive daytime sleepiness ☐ tremor ☐ non-restorative sleep ☐ weakness ☐ numbness in extremities ☐ other: __________________ ☐ ALL NEGATIVE
Respiratory ☐ apnea during sleep ☐ shortness of breath ☐ snoring ☐ wheezing ☐ other: __________________ __________________________ ☐ ALL NEGATIVE	**Genitourinary** ☐ change in urine color ☐ dysuria ☐ urinary frequency ☐ other: __________________ _________________________ ☐ ALL NEGATIVE	**Psychiatric** ☐ anxiety ☐ depression ☐ hallucinations ☐ other: __________________ __________________________ ☐ ALL NEGATIVE

Patient Signature: ____ Date: __________