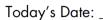
WELCOME TO OUR OFFICE



PATIENT INFORMATION

Last:
First: MI:
Patient's SSN:
Date of Birth: Age:
Gender: O Male O Female
Street:
City: State: Zip Code:
Race: Ethnicity:
Primary Language: O English O Other:
Home Phone: ()
Work Phone: ()
Email:
Cell Phone/ Primary Contact: ()
Employer/School:
Occupation/Grade:
Spouse/Parent's Name:
Spouse/Parent's Work:
WHOM SHOULD WE NOTIFY IN CASE OF AN EMERGENCY?
Name Telephone Relationship
Name Telephone Relationship What is the major purpose of this visit?
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At **Jeffrey Joseph MD**, our aesthetic approach focuses on the eyes as the center from which we derive our facial identity and appearance.

Dr. Joseph offers the unique ability to ensure the safest and most cosmetically appealing results after surgery while protecting and potentially improving the health of the eyes and vision.

Our practice is dedicated to providing patients with sub-specialized, consultative care, all in a boutique environment with a concierge experience.

INSURANCE INFORMATION

Primary Medical Insurance _____

Subscriber Name ______ Subscriber SSN ______

Subscriber Birth Date _____

I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY CHARGES NOT COVERED BY MEDICAL OR VISION INSURANCE:

(SIGNATURE)

(DATE)

PHYSICIAN & PHARMACY

Who is Your Primary Care Physician:

City	Phone ()
Preferred Pharmacy		
Pharmacy Phone (if known)	()	
, , ,	· · · —	



PATIENT HISTORY

_ Today's Date: _____

Patient Name: _____

Birth Date: _____

A	PAST OCULAR HISTORY: Have you been diagnosed with ANY eye problems? (e.g. cataracts, glaucoma, macular degeneration, retinal problems, etc.)				
▼ O Yes	O No				
Please list all Ocula	r Problems/Surgeries:	Date	Left Eye/ Right Eye / Both?		

В	PAST FACIAL PROCEDURES: Have you had ANY facial surgeries or procedures?	
▼ O Yes	O No	
Please list all previo	ous FACIAL PROCEDURES:	Date

С	(e.g. thyroid problems, g	PAST SYSTEMIC ILLNESSES: Have you had ANY past systemic illnesses? laucoma, diabetes, hypertension (high blood pressure), heart disease, cancer, respiratory issues, etc.)
▼ O Yes	O No	
Please lis	t ALL PAST MEDIC	AL ILLNESSES:

HEAD/OCULAR TRAUMA Have you had ANY of the past head or ocular trauma? (e.g. falls, head concussions, motor vehicle accidents, etc.)			
▼ O Yes	O No		
Please list all PAST HEAD/OCULAR TRAUMA: Date of injury			

PAST BODILY SURGERIES Have you had any general/bodily surgeries or proced Please list ALL past surgeries	lures?
O No	
us GENERAL SURGERIES:	Date of surgery
	Please list ALL past surgeries O No



O Yes O No

FAMILY AND SOCIAL HISTORY Do any of your family members have ANY medical or eye diseases? If YES, please note relationship to patient. Relationship Disease No Follow Up Questions Yes Macular degeneration 0 0 Do you smoke? Glaucoma \circ \circ If yes how much?

Do

0			
Glaucoma	0	0	If yes, how much? packs per day?
Retinal problems	0	0	
Lazy eye	0	0	Former smoker? O Yes O No
Blindness	0	0	
Diabetes	0	0	Do you drink alcohol? O Yes O No
High blood pressure	0	0	If yes, how much? drinks per day?
Heart disease	0	0	
Respiratory disease	0	0	
Cancer	0	0	
Thyroid/Autoimmune disease	0	0	
Comments:			

REVIEW OF ⁻	THE SYSTEMS
you currently have any	of the following problems?

	Questions	Yes	No	If YES, please explain
1.	Do you have any allergies to any medication?	0	0	
2.	Constitutional (fever, weight loss, fatigue, other)	0	0	
3.	Eyes (glaucoma, cataract, lazy eye, retina problems, other – please specify)	0	0	
4.	Ear Nose Mouth Throat (hearing loss, sinus problems, sore throat, difficulty breathing)	0	0	
5.	Cardiovascular (heart problems, chest pain, irregular heart beat)	0	0	
6.	Respiratory (asthma, shortness of breath, wheezing , coughing)	0	0	
7.	Gastrointestinal (heartburn, abdominal pain, diarrhea, vomiting)	0	0	
8.	Genitourinary (urinary problems, blood in urine)	0	0	
9.	Integumentary (skin rashes, excessive dryness)	0	0	
10.	Musculoskeletal (muscle aches, joint pain, swollen joints)	0	0	
11.	Neurological (numbness, weakness, headaches, paralysis)	0	0	
12.	Hematologic/ Lymphatic (blood disorders, leukemia)	0	0	
13.	Allergic/ Immunologic (hay fever, allergies)	0	0	
14.	Endocrine (thyroid problems, diabetes, autoimmune disease)	0	0	
All Information	n is Privileged & Confidential		inFocus	Form - Welcome to our Office IES 20200803scs Page 3 of 4

All Information Provided Is Privileged & Confidential





CURRENT MEDICATIONS Are you currently taking ANY medications or vitamins/supplements? If YES, please list all with included milligrams and times per day if known:

Patient Name: _____

_ Today's Date: _____

Birth Date: _____

Medication Name	Strength (mg.)	Frequency Taken

Thank you!