WELCOME TO OUR OFFICE

JEFFREY JOSEPH
OPHTHALMIC PLASTIC SURGERY

Today's Date: _____

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*

What is the major purpose of this visit?

_____
_____
_____
_____
_____

VERY IMPORTANT!

Whom may we thank for referring you to our office?

O Current Patient: _____
O Referring Doctor: _____
Primary Care Physician or Other Medical Professional
O Referring Optometrist:_____
City: _____ State: _____
O Name of friend or relative _____

IF NOT REFERRED, HOW DID YOU CHOOSE OUR OFFICE?

O Insurance List
O Saw Sign/Building
O Newspaper/Radio/TV
O Yellow Pages: Which Directory?
O Web Page: Which Website?

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 Name: _____ Today's Date: _____

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 Ocular Problems/Surgeries:	Date	Left Eye/ Right Eye / Both?

B PAST FACIAL PROCEDURES:

Have you had ANY facial surgeries or procedures?

▼ O Yes O No

Please list all previous FACIAL PROCEDURES:	Date

C PAST SYSTEMIC ILLNESSES:

Have you had ANY past systemic illnesses?
(e.g. thyroid problems, glaucoma, diabetes, hypertension (high blood pressure), heart disease, cancer, respiratory issues, etc.)

▼ O Yes O No

Please list ALL PAST MEDICAL ILLNESSES:

D 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

E PAST BODILY SURGERIES

Have you had any general/bodily surgeries or procedures?
Please list ALL past surgeries

▼ O Yes O No

Please list all previous GENERAL SURGERIES:	Date of surgery

F FAMILY AND SOCIAL HISTORY

Do any of your family members have ANY medical or eye diseases?
If YES, please note relationship to patient.

Disease	Yes	No	Relationship
Macular degeneration	○	○	
Glaucoma	○	○	
Retinal problems	○	○	
Lazy eye	○	○	
Blindness	○	○	
Diabetes	○	○	
High blood pressure	○	○	
Heart disease	○	○	
Respiratory disease	○	○	
Cancer	○	○	
Thyroid/Autoimmune disease	○	○	

Follow Up Questions

Do you smoke? ○ Yes ○ No
If yes, how much? ____ packs per day?

Former smoker? ○ Yes ○ No

Do you drink alcohol? ○ Yes ○ No
If yes, how much? ____ drinks per day?

Comments: _____

_____

_____

G REVIEW OF THE SYSTEMS

Do you currently have any of the following problems?

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

H

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!