ARIZONA OCULAR &
FACIAL PLASTIC SURGERY

8415 N Pima Rd. Suite 100, Scottsdale, AZ 85258
Main: 480-949-5990; Fax: 480-949-0509

PATIENT INFORMATION **Appointment Date:**_____

NAME:_____SEX:_____NICKNAME:_____

DATE OF BIRTH:_____AGE:_____MARITAL STATUS:_____

ADDRESS:_____UNIT #:_____

CITY:_____STATE:_____ZIP:_____

HOME PHONE #:_____CELL #:_____

EMAIL: _____SS#:_____

PREFERRED METHOD OF CONTACT *(circle one):* Home Phone Cell Phone Text Email

PREFERRED PHARMACY W/CROSS STREETS:_____

DRIVER'S LICENSE #: _____ STATE:_____

EMPLOYMENT STATUS *(circle one):* Full Time Part Time Self Retired Not Employed Disabled

EMPLOYER:_____EMPLOYER PHONE #_____

Race_____ ☐ I decline to answer this question
Ethnicity:_____ ☐ I decline to answer this question

How did you hear about our office? *(circle one)* Google Instagram Facebook Yelp Employee Insurance Family/Friend

Doctor's Office/Group_____Dr.'s Name_____

IN CASE OF EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT:_____RELATIONSHIP TO PATIENT:_____
HOME PHONE:_____CELL PHONE:_____

We are required by federal statute to ask the following questions:

INSURANCE INFORMATION

PRIMARY INSURANCE NAME:_____

MEMBER ID #:_____ GROUP #:_____

PRIMARY NAME OF INSURED:_____ DATE OF BIRTH:_____

INSURED'S SS#:_____ RELATION TO THE PATIENT:_____

SECONDARY INSURANCE NAME:_____

MEMBER ID #:_____ GROUP #:_____

PRIMARY OF INSURED:_____ DATE OF BIRTH:_____

INSURED'S SS#:_____ RELATION TO THE PATIENT:_____

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PATIENT HEALTH HISTORY

Name:_____DOB_____

AGE:____WEIGHT:_____HEIGHT:_____ Contacts? Rt___Lt___ Hearing Aids? Rt____Lt____ Do You Have Pain? YES / NO

Are you on a Narcotics Contract? Yes___ No___If Yes, Name of Physician Prescribing:_____

DOCTORS- Please list all the doctors involved in your care.

NAME	REASON	PHONE NUMBER
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICAL (Past and Current)

HEART AND VASCULAR

__Heart Attack(s) DATE(s)_____
__Angina/Chest Pain
__Murmur
__Abnormal Rhythm
__High Blood Pressure
__Heart Failure
__Pacemaker
__Mitral Valve Prolapse
__High Cholesterol
__Other_____

LUNGS

__Asthma/Wheezing
__Emphysema
__Bronchitis
__Chronic Cough
__TB (or family history)
__Shortness of Breath
__Recent Cough/Cold
__Sleep Apnea
__Other:_____

GENITAL/URINARY

__Kidney or Renal
__Dialysis Schedule:_____
__Other:_____

GASTRO-INTESTINAL

__Liver Disease
__Jaundice
__Hiatal Hernia __Reflux
__Other:_____

BLOOD & COAGULATION

__Aids/HIV
__Hepatitis
__Anemia
__Bruising
__Other:_____

NERVOUS SYSTEM

__Stroke
__Seizures/Epilepsy
__Head or Neck Injury
__Other:_____

ENDOCRINE

__Diabetes
__Insulin
__Thyroid Disease
__Other:_____

MUSCULO-SKELETAL SYSTEM

__Chronic Back Pain __Neck Trouble
__Arthritis
__Multiple Sclerosis
__Other:_____

OTHER

__Glaucoma __Rt __Lt

__Hearing Loss __Rt __Lt
__Breastfeeding
__Cancer: Type_____
__Pregnant
__Other_____

SURGICAL HISTORY

LIST PREVIOUS SURGERIES/INJURIES/HOSPITALIZATIONS OR PROCEDURES (INCLUDE ALL EYE SURGERIES) ☐ **NONE**

DATE	PROCEDURES
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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MEDICATIONS AND ALLERGIES

Name:_____**DOB**:_____

MEDICATIONS: ☐ *I DO NOT TAKE ANY MEDICATIONS*

NAME OF MEDICATION Bring a list of medications	DOSAGE OF MEDICINE: mg, units, cc's	HOW OFTEN TAKEN

PLEASE CHECK ANY OVER-THE - COUNTER MEDICINES YOU ARE PRESENTLY TAKING:

NONE
Antacids
Aspirin Products
Cold/Cough Meds
Diarrhea Preps
Laxatives
Eye Drops
Herbal Remedies
Vitamin/Supplements
Pain Medicines
Weight Loss Meds
Recreational Drugs
Other:_____
_____
_____
_____

Have you taken any blood thinners or aspirin in the last 3 months? **Yes__ No__**

MEDICATION ALLERGIES: ☐ *NO KNOWN ALLERGIES*

NAME OF MEDICATION/ALLERGY	REACTION

Are you sensitive to any of the following?
Iodine ☐Topical ☐ Tape
Injected IV ☐Latex ☐Cloth
Paper
Reaction:_____
_____

ANESTHESIA REACTIONS:

Have you had any complications related to anesthesia? __YES ____NO __General __Local

Describe Reaction:_____ Malignant Hyperthermia: ___YES ___NO

Photo Release: Photographs are taken of me, or parts of my body may be used in any print or broadcast media, including but not necessarily limited to newspapers, pamphlets, educational films, our internet site, and television, in order to inform the public about plastic surgery methods. My consent is subject only to the condition that I am not identified by name at any time during any use or publication of these materials by any party. YES_____ Decline_____

The undersigned acknowledges that the above information is true and correct.

Signature:_____**Date:**_____
(Patient/Legal Advocate)

ARIZONA OCULAR &
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Dustin M Heringer, MD

HIPAA NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

OUR COMMITMENT TO YOUR PRIVACY.....

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information.:

Use and disclosure of your health information in certain special circumstances.

The following circumstances may require us to use or disclose your health information:

1) To public health authorities and health oversight agencies that are authorized by law to collect information.
2) Lawsuits and similar proceedings in response to a court or administrative order.
3) If required to do so by a law enforcement official.
4) When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5) If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6) To federal officials for intelligence and national security activities authorized by law.
7) To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8) For Workers Compensation and similar programs.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request, however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. YOU MUST SUBMIT YOUR REQUEST IN WRITING TO: Arizona Ocular & Facial Plastic Surgery, Attn: Medical Records.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made, IN WRITING, and submitted to: Arizona Ocular & Facial Plastic Surgery, Attn: Practice Administrator. You must provide us with a reason that supports your request for amendment. Your records will be reviewed, and a determination made within 60 days.
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time. To obtain a copy of this notice, contact our front desk receptionist.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint about our practice, contact: Jeanette Bren, Practice Administrator 480-291-5469. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.
8. If you have any questions regarding this notice or our health information privacy policies, please contact: Jeanette Bren, Practice Administrator 480-291-5469.

I hereby acknowledge that I have been presented with a copy of Arizona Ocular & Facial Plastic Surgery Notice of Privacy Practices.

Print Name:_____

Signature:_____ Date:_____

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Dustin M Heringer, MD

FINANCIAL POLICY

Thank you for choosing **Arizona Ocular & Facial Plastic Surgery** as your medical provider. We are dedicated to providing personalized service for each patient and we believe our financial policies support our commitment to excellence in patient care. A patient's medical treatment protocols are created by the physician to suit each patient's clinical needs and are never based on a patient's financial situation. The following financial policy is required to be read and signed before your initial visit with us.

Since patient is very important, we require all patients to complete our registration (patient) information form prior to their initial visit and on an annual basis. In order to ensure accurate information and efficiency, please do not be offended if we periodically request updates on new demographic as this could frequently change.

All services and medical supplies provided by *Arizona Ocular & Facial Plastic Surgery* should be completely paid for at the time of service. You will receive a statement showing, in detail, charges incurred during the statement period and the amount due. All fees are payable within 30 days of receiving the statement. **As the patient you are responsible for complete payment of any charges that you incur whether covered by your insurance or NOT covered by your insurance.**

Late Appointments: We understand you may run late, however if you are more than 15 minutes late, you may be subject to be rescheduled. The providers provide this 15-minute window in the off chance you are running late and ask that you respect their time, if you feel you may be running over this allotted time, please understand you will be rescheduled.

Missed Appointments: We require scheduled visits to be cancelled ***no later than 24 hours prior to your appointment.***

DELINQUENT ACCOUNTS: If your account should become delinquent for more than ninety (90) days, the account will be turned over to an outside agency for further collection. You will then be dismissed from the practice and will not be able to return as a patient thereafter or in the future. ***In the unfortunate event that an account is given to a collection agency or to an attorney for collection, then the patient/responsible party shall pay to Arizona Ocular & Facial Plastic Surgery all costs of collection fees.*** If you should have any concerns regarding this policy, please contact the office prior to ninety (90) days so that we may assist you with a solution.

This assignment will remain in effect until revoked by me in writing.

Date:_____

Print Name:_____

Signature:_____