OCULOPLASTICS, LLC
RAYMOND MAGAURAN, MD

55 St. George Road,
Springfield, MA 01104

Tel: (413) 276-4543
Fax: (413) 304-3838
Oculoplasticsllc.com

WELCOME!

Thank you for choosing us for your care.

Please bring the following with you for the first appointment:

- complete the paperwork on the next few pages
- your insurance cards
- a list of your current medications including over-the-counter products and dietary supplements
- any other medical information you feel may be pertinent to your care
- copies of any tests performed by your referring physician including but not limited to: visual fields or side vision tests, CT scans, MRI's and pathology reports.
- If you are having problems related to recent surgery performed by another physician, it would also be helpful to bring a copy of the operative notes and any other records from that physician.

Your initial visit is scheduled as an evaluation only; we cannot promise to perform procedures at the time of your first visit. We will make every effort to accommodate your needs and deliver your healthcare as efficiently as possible. Please ensure you have obtained a referral from your primary care provider prior to your appointment if your insurance requires it.

Your appointment is scheduled for:

_____

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NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT AND CONSENT TO MEDICAL TREATMENT

Patient Name: _____

Date of Birth: _____

I have received and understand this practice's Notice of Privacy Practices written in plain English. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise those rights, and the practices legal duties with respect to my information.

I understand that the practice reserves the right to change the terms of the Privacy Practices, and to make changes regarding all protected health information. If changes occur then the practice will provide me with a revised copy upon request.

I voluntarily consent to care, including physician examination and tests such as x-ray, laboratory tests and to medical treatment by my physician or his/her assistants or designees, as may be necessary in the judgment of my physician. No guarantees have been made to me as the result of treatment or examination.

Authorization for:

In consideration for services received by Oculoplastics, LLC I agree to pay any and all charges as billed. I also request that direct payments be made to Oculoplastics, LLC on my behalf by insurers and agencies in the settlement of any of my claims. I understand that my protected health information may need to be released for the purpose of treatment, payment or health care operations.

Medicare Patients:

I certify that the information given by me for application for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other relevant information about me be released to the Social Security Administration or it's intermediaries of carriers and such information needed to support application for payment, including records pertaining to HIV status or treatment (AIDS records), drug and alcohol treatment, and or psychiatric treatment. I assign and authorize payment directly to Oculoplastics, LLC for the unpaid charges.

_____ _____

Signature ***Date***

New Patient Information

▲PATIENTS NAME _____

▲BIRTH DATE _____ ▲SEX _____ ▲ AGE _____ ▲DATE (MM/DD/YY) _____

▲SOC SEC NO. _____ ▲ PRIMARY CARE PHYSICIAN _____

PERSONAL INFORMATION

Address: _____ (Street) _____ (City) _____ (State) _____ (Zip)

Phone: Home (___) _____ Work (___) _____

Occupation: _____ Employer: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Spouse Name: _____ Employer: _____

Complete if under 18 years or a student

Responsible Adult _____ Employer _____

Address _____ Phone (___) _____

CONTACT CHOICES

☐ Mail ☐ Home Phone ☐ Cell Phone ☐ Allow Voice Message

☐ Allow E-mail: _____ ☐ Allow SMS/text message

☐ Access Patient Portal -> request Username: _____

HOW DID YOU HEAR ABOUT US?

Referred by : ☐ Friend/Relative _____ (Name) ☐ Doctor _____ (Name)

☐ Online/Google ☐ Radio ☐ Newspaper ☐ Salon _____

☐ Postcard ☐ Other _____

INSURANCE INFORMATION

☐ Medicare # _____ ☐ Medicaid # _____

☐ Workers Compensation (job injury) to whom is bill to be sent? _____

☐ Other Medical Insurance _____

Group # _____ ID# _____

Name/Address 2nd Insurance _____

Are you personally responsible for the payment of your fees? ☐ Yes ☐ No If not, who is?

Name _____ Relationship _____ DOB _____

Who to notify in emergency (nearest relative or friend)?

Name _____ Relationship _____

Address _____

Home Phone (___) _____ Work Phone (___) _____

Oculoplastics, LLC
PATIENT HISTORY RECORD

▲PATIENTS NAME _____ ▲ AGE _____

Please answer the following questions about your medical status and history:

1. Have you ever been treated for any medical conditions (e.g., diabetes, high blood pressure, arthritis, etc)
   Yes☐ No☐ If YES, please explain: _____
2. Have you ever had any eye disease (e.g., glaucoma, cataract, wandering or "lazy" eye, retinal detachment)?
   Yes☐ No☐ If YES, please explain: _____
3. Have you ever had any surgery:
   Yes☐ No☐ If YES, please provide date and reason _____
4. Have you ever been hospitalized
   Yes☐ No☐ If YES, please provide date and reason _____
5. Do you take any medications?
   Yes☐ No☐ If YES, please list: _____
   Do you take any eye medications?
   Yes☐ No☐ If YES, please list: _____
6. Do you have any drug or food allergies?
   Yes☐ No☐ If YES, please list: _____

Family and Social History

Do any medical or eye diseases run in your family *(e.g., diabetes, high blood pressure, cancer, glaucoma, macular degeneration)*
Yes☐ No☐ If YES, please explain: _____

Do you smoke? If yes, how much? ☐ Drink alcohol? If yes, how much? ☐

If employed, how many hours per week do you work? ☐ Occupation: ☐

Review of Systems

Do you currently have any of the follow problems:

	Yes	No	If YES, please explain:
Chronic fever, unexpected weight loss/gain, fatigue	☐	☐	
Ear/nose/throat problems **(e.g., hearing loss, sinus problems, sore throat)**	☐	☐	
Heart problems **(e.g. chest pain, irregular heart beat)**	☐	☐	
Respiratory problems **(e.g., shortness of breath, wheezing, coughing)**	☐	☐	
Gastrointestinal problems **(e.g. heartburn, abdominal pain, diarrhea, vomiting)**	☐	☐	
Urinary problems **(e.g. pain or discomfort, blood in urine)**	☐	☐	
Skin problems **(e.g. rashes, excessive dryness)**	☐	☐	
Musculoskeletal problems **(e.g., muscle aches, joint pain, swollen joints)**	☐	☐	
Neurologic problems **(e.g., numbness, weakness, headaches, paralysis)**	☐	☐	
Psychiatric problems **(e.g., depression, anxiety)**	☐	☐	

Review of Systems

Do you any other concerns you would like to share::

_____

_____

▲ **Comments**

▲ **M.D. Signature** ▲ **Date**