PHILIP R. RIZZUTO, MD, FACS

Rizzuto Eyelid & Facial Plastic Surgery
120 Dudley Street Suite 301
Providence, RI 02905
401-274-6622 fax 401-490-7051

PATIENT REGISTRATION - *PLEASE COMPLETE BOTH SIDES OF ALL FORMS*

Patient________________________________ Date________________________

Street ____

City, State, ZIP ____

Mobile Phone______________ May we text you? YES/NO ____ Home/Work Phone ________________

Date of Birth______________________ Social Security Number ______________________

Age__________ Sex: Male Female Marital Status: Single Married Divorced Widowed

Preferred Language______________ Race______________ Ethnicity ______________

Email ____

Relative or friend we can call if we are unable to contact you:

Name____

Relationship to the patient______________________ Phone number______________________

Health Insurance in patient's name

Plan______________________________

ID number__________________________

Plan______________________________

ID number__________________________

Health Insurance in other's name

Plan ______________________________

ID number __________________________

Subscriber's name____________________

Subscriber's date of birth ______________

Relationship to patient________________

Patient's (or Subscriber's) employment

Employed? Yes No Retired

Date of retirement____________________

Occupation__________________________

Employer____________________________

Total number of employees, if known__________

Work address________________________

City, State, ZIP______________________

Work phone number___________________

Spouse's employment

Spouse employed? Yes No Retired

Date of retirement ____________________

Occupation __________________________

Employer____________________________

Total number of employees, if known __________

Work address ________________________

City, State, ZIP ______________________

Work phone number___________________

If your present condition is the result of an injury:

Date of injury________________________

Accident-related injury? Yes No

Work-related injury? Yes No

Personal injury claim? Yes No

Workmen's Compensation contact name:

____

Phone number ________________________

Attorney's name ______________________

Phone number ________________________

Insurance company ____________________

Phone number ________________________

Referred by______________________

Phone number________________________

Medical doctor____________________

Phone number________________________

Eye doctor_______________________

Phone number________________________

Please designate your pharmacy

Pharmacy name_______________________

Street______________________________

City, State, ZIP_____________________

Pharmacy phone______________________

Pharmacy fax________________________

AUTHORIZATION AND ASSIGNMENT OF BENEFITS

☐ Philip R. Rizzuto, MD, FACS

Patient____

Release of Medical Records I hereby authorize any hospital, physician, medical practitioner, clinic, other medical or medically related facility, pharmacy, insurance company, or government agency to disclose or furnish to the provider named any and all information with respect to any medical condition including injury, medical history, consultation, or treatments, and copies of all applicable records that may be requested. A xerographic copy of this authorization is to be considered as valid as the original.

Electronic Transmission My records may be transmitted electronically, and I authorize the provider named to do so. If they are received by another party in error, I absolve the provider named of all and any liability relating to such submission of said records.

Telehealth I will consent to a telehealth visit.

Photography Consent Photographs may be taken for diagnostic purposes, medical records, and documentation. I hereby authorize further use of those photographs for teaching purposes, to illustrate scientific papers or medical books, at any time hereafter without inspection or approval on my part of the finished product or specific use to which these photographs may be applied. I understand that my name will not be disclosed when the photos are used for these teaching purposes, and in most circumstances full-face is not used.

Assignment of Benefits I request that payment of medical benefits, or authorized Medicare benefits, be made on my behalf to the provider named for any services furnished me by that provider. I authorize any holder of medical information about me to release to any agency or insurance company or (for Medicare beneficiaries) to the Health Care Financing Administration and its agents, any information needed to determine these benefits payable for related services.

Acknowledgement I understand this assignment does not lessen my financial responsibility for any charges not covered by this authorization.

____ _________________________

Signature of Patient or Representative Date

____

Representative's Relationship to Patient

PATIENT REGISTRATION - **PLEASE COMPLETE BOTH SIDES OF ALL FORMS**

Patient____

Notice of Privacy Practices provides information about how we use and disclose protected health information about you. The notice contains a *Patient Rights* section describing your rights under the law. You have the right to review our notice before signing this consent. The terms of our notice may change. If we do change our notice, you may obtain a revised copy by contacting our office.

By signing this form, you consent to Philip R. Rizzuto, MD, FACS use and disclosure of protected health information about you for treatment, payment, and health care operations. This includes any photographs taken for diagnostic purposes. You have the right to revoke this consent, in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in reliance on your prior consent. Ophthalmic Plastic Surgery provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, and health care operations.
- Philip R. Rizzuto, MD, FACS has a Notice of Privacy Practices and that the patient has had the opportunity to review this notice.
- Philip R. Rizzuto, MD, FACS reserves the right to change the Notice of Privacy Practices.
- The patient may revoke this consent in writing at any time and all future disclosures will then cease.
- Philip R. Rizzuto, MD, FACS may condition treatment upon the execution of this consent form.

This consent was signed by:

____ _________________________

Signature of Patient or Representative Date

____

Relationship to Patient (if other than patient)

____

Signature of Practice Representative

MEDICAL HISTORY QUESTIONNAIRE

Patient____________________ Date____________________

VISION HISTORY

Do you wear:

YES NO Glasses
YES NO Contact lenses
YES NO An artificial eye

Have you ever had:

YES NO Cataract
YES NO Glaucoma
YES NO Diabetes
YES NO Lazy eye
YES NO Double vision
YES NO Floaters
YES NO Halos
YES NO Flashing lights
YES NO Abnormal light sensitivity
YES NO Blind spots
YES NO Jagged lines in your vision
YES NO Poor side vision
YES NO Poor night vision
YES NO Poor color perception
YES NO Poor depth perception
YES NO Retinal problems
YES NO Poor blood supply to the eye
YES NO Serious eye infection
YES NO Abnormal pupil
YES NO Other, *if so*, what?

____

____

FAMILY EYE HISTORY

Has anyone in your immediate family ever had:

YES NO Cataracts
YES NO Glaucoma
YES NO Diabetes
YES NO Macular degeneration
YES NO Retinal problems
YES NO Blindness form of any cause
YES NO Hereditary eye problem
YES NO Other eye disorders, *if so*, what?

____

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EYE, EYELID, TEARING HISTORY

Do you have or have been treated for:

YES NO Dry eyes
YES NO Red eyes
YES NO Itchy eyes
YES NO Wet eyes
YES NO Overflowing tears
YES NO Eye that bulges
YES NO Pressure in/behind the eye
YES NO Lids/lashes stick together
YES NO Pus around the eye
YES NO Crusting or red lids
YES NO Lazy or droopy eyes
YES NO Lid retraction
YES NO Thyroid eye disease
YES NO Eye that turns in or out
YES NO Eye or eyelid growths
YES NO Spasms of the lids or face
YES NO Facial weakness or palsy
YES NO Eye, lid, or facial injury
YES NO Eye surgery, *if so*, what?

____

____

YES NO Other, *if so*, what?

____

____

SOCIAL HISTORY

YES NO Do you smoke now?
How much?__________

____

YES NO Have you ever smoked?
How many years?______
How much?__________
When did you stop?____

____

YES NO Do you drink alcohol?
How much?__________
How often? __________

YES NO Did you drink in the past?
How much?__________
How often? __________

YES NO Have you ever used IV drugs?
YES NO Are you pregnant?

MEDICAL HISTORY

Do you have or have been treated for:

YES NO Diabetes
YES NO High blood pressure
YES NO Low blood pressure
YES NO Thyroid problems
YES NO Lung problems
YES NO Bleeding problems
YES NO Hardening of the arteries
YES NO Strokes
YES NO Seizures
YES NO Myasthenia
YES NO Cancer
YES NO Skin cancer
YES NO Hepatitis
YES NO Asthma
YES NO Arthritis
YES NO Ulcers
YES NO Lupus
YES NO Multiple sclerosis
YES NO Heart problems
If so, what type:
YES NO Angina
YES NO Congestive heart failure
YES NO Myocardial failure
YES NO Heart valve disease
YES NO Chest pain
YES NO Shortness of breath
YES NO Other heart disease
If so, what?____________

____

____

YES NO Hypercholesterol
YES NO Sleep Apnea
YES NO C-Pap
YES NO Other medical problems?
If so, what?____________

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MEDICAL HISTORY QUESTIONNAIRE - continued

Patient______________________________ Date________________

SURGICAL HISTORY

YES NO Have you ever had a reaction to ***general*** anesthesia?

YES NO Have you ever had a reaction to ***local*** anesthesia?

YES NO Have you ever had a blood transfusion?
When?____________

YES NO Have you ever had surgery or laser surgery?
If so, please list any surgery you have had and the date:

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ALLERGIES

YES NO Penicillin

YES NO Sulfa

YES NO Shellfish

YES NO Latex

YES NO Epinephrine

YES NO Betadine/Iodine

YES NO Are you allergic to any other medicine?
If so, please list the medicine and the reaction it caused:

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CURRENT MEDICATION

YES NO Are you currently taking any medication?

List all of your current prescription and non-prescription medicines and dosages. Refer to the labels for accuracy. Include any pills, liquids, drops, ointments, injections, powders, or other medicines.
(For example: Aspirin, Eye drops, Coumadin, Birth control pills, etc.)

Name, Strength (mg etc.)**, How often**

If you take more than 8 medications
Please attach a list

____

____

____

____

____

____

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____

____

REVIEW OF SYMPTOMS

CONSTITUTIONAL SYMPTOMS

YES NO Change in general health

YES NO Change in strength

YES NO Fever

YES NO Weight loss

CARDIOVASCULAR

YES NO Pain in chest

YES NO Palpitations

YES NO Shortness of breath

YES NO Difficulty breathing lying down

YES NO Swelling in the ankles

RESPIRATORY

YES NO Cough

YES NO Spitting up blood

GASTROINTESTINAL

YES NO Change in appetite

YES NO Heartburn

YES NO Nausea

YES NO Vomiting

YES NO Vomiting blood

YES NO Jaundice

YES NO Dark urine

GENITOURINARY

YES NO Pain on urination

YES NO Change in frequency of urination

YES NO Blood in urine

NEUROLOGICAL

YES NO Insomnia

YES NO Convulsions

YES NO Weakness

YES NO Change in memory

PSYCHIATRIC

YES NO Any change in mood

YES NO Depression

YES NO Anxiety

ENDOCRINE

YES NO Enlargement of thyroid

YES NO Heat or cold intolerance

YES NO Changes in the hair

YES NO Breast nodules

HEMATOLOGIC/LYMPHATIC

YES NO Easy bruising or bleeding

YES NO Anemia

YES NO Swelling of the lymph glands

SKIN

YES NO Abnormal moles

YES NO Bleeding

YES NO Skin lesions

YES NO Breast lumps

YES NO Rash

YES NO Eruptions

YES NO Itching

YES NO Pigmentation or loss of pigmentation

YES NO Sweating

YES NO Alteration in hair or nails

YES NO Abnormal scarring or keloids

YES NO Cold sores

CREDIT CARD FILE POLICY

At *Philip R. Rizzuto, MD LTD* we require keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable. Without this authorization, a billing fee will be added to your account for any balances that we must attempt to collect through mailing monthly statements. Furthermore, an "outstanding balance" charge of 1.5 percent of the total bill will be charged for each month that the bill remains unpaid.

Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been filed and processed by your insurer and the insurance portion of the claim has paid and posted to the account.

I authorize *Philip R. Rizzuto, MD LTD* to change the portion of my bill that is my financial responsibility to the following credit or debit card:

HSA Amex Visa Mastercard Discover

Credit Card Number ____

Expiration Date ____ / _____/ _____

Cardholder Name ____

Signature ____

Billing Address ____

City _______________ State ______ Zip _______

I (we), the undersigned, authorize and request Philip R. Rizzuto, MD LTD to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility.

This authorization relates to all payments not covered by my insurance company for services provided to me by *Philip R. Rizzuto, MD LTD*.

This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60 day notification to *Philip R. Rizzuto, MD LTD*.

In writing and the account must be in good standing.

Patient Name (Print): _______________________________________

Patients Signature: _______________________________________

Date ____ / ____ / ____

<u>Some insurance plans</u> require a **referral** from your **primary care physician (PCP)** before seeing Dr. Rizzuto, who is considered a specialist.

<u>Steps to obtain a referral</u>

1. You must call your insurance company and ask if you need a referral to see Dr. Rizzuto. The member services phone # is on the back of your insurance card.
   a. If **YES,** continue with the steps below; If **NO,** this letter does not pertain to you.

2. Call your PCP to fax to 401-490-7051 a referral to Dr. Rizzuto for your upcoming appt.
   a. Your PCP may need (ICD-10) or diagnosis code(s), please give them the following ____

3. You must call Dr. Rizzuto's office 1-2 days prior to your appointment (401) 274-6622 to be sure we have a referral from your PCP.
   a. If we do not have one, we will gladly see you for your scheduled appointment, however we are not allowed to bill your insurance, and you will be financially responsible for that day's visit.
   b. Once we receive the referral from your PCP, we will reimburse you; Or we are happy to reschedule your appointment to allow time for your PCP to fax us the referral.

4. Patients are responsible for copays, deductibles, co-insurance, out of pocket expenses and referrals as they pertain to your insurance coverage