

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?*
- _____

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? _____
- _____

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:

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:

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

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 ON 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. 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 been paid and posted to the account.

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*.

Patient Name (Print): _____

Patients Signature: _____

Date ____ / ____ / ____

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

Steps to obtain a referral

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