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

<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.

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