OPHTHALMIC PLASTIC SURGERY
PLASTIC AND RECONSTRUCTIVE SURGERY
COSMETIC SURGERY

CERTIFIED BY
THE AMERICAN BOARD OF PLASTIC SURGERY
THE AMERICAN BOARD OF OPHTHALMOLOGY

PATIENT REGISTRATION

DR.
MR.
MS.
MRS.
MISS

(FULL LEGAL) LAST NAME _____

FIRST NAME _____

MI _____

May we call all numbers and email you? _____

(_____)_____
HOME PHONE

(_____)_____
BUSINESS PHONE

(_____)_____
CELL OR MOBILE PHONE

EMAIL ADDRESS _____

ADDRESS _____ STREET APT _____ CITY _____ STATE ZIP

SOC. SEC. #: _____ DOB: _____/_____/_____ AGE: _____

EMPLOYER NAME _____ OCCUPATION _____

ADDRESS _____ STREET APT _____ CITY _____ STATE ZIP

EMERGENCY CONTACT

FIRST NAME _____ LAST NAME _____

RELATIONSHIP _____

(_____)_____
HOME PHONE

(_____)_____
CELL PHONE

(_____)_____
WORK PHONE

SPOUSE

FIRST NAME _____ LAST NAME _____

SPOUSE'S EMPLOYER _____ DATE OF BIRTH _____

SPOUSE'S OCCUPATION _____

(_____)_____
CELL PHONE

(_____)_____
WORK PHONE

REFERRED BY: _____ (_____)_____
Doctor Patient (Circle one) PHONE NUMBER

PHOTOGRAPHS

I hereby authorize Glenn W. Jelks, M.D., P.C. to take pre-operative and post-operative photographs for documentation, as well as for possible publication in scientific medical literature.

_____
Signature of Patient/Guardian Date

PATIENT HEALTH HISTORY

NAME: _____ DATE: _____

CIRCLE WHICH OF THE FOLLOWING YOU WISH TO DISCUSS WITH THE DOCTORS?

FACE	UPPER EYELIDS	NECK	BREASTS	NOSE
EARS	LOWER EYELIDS	CHIN	ABDOMEN	SUCTION
FILLERS	ABNORMAL SKIN GROWTHS		OTHER_____	

EXPLAIN ANY SPECIAL CONCERNS REGARDING ITEMS CIRCLED:

HAVE YOU CONSULTED ANOTHER PLASTIC SURGEON FOR ANY OF THE ABOVE?

LIST ALL SURGERY DONE BY A PLASTIC SURGEON AND THE YEAR OF SURGERY:

WERE YOU SATISFIED WITH THE RESULTS OF THE PREVIOUS PLASTIC SURGERY?
YES NO SOMEWHAT

PLEASE LIST OTHER PAST SURGERIES AND THE YEAR PERFORMED (E.G. TONSILS, C-SECTION):

EXPLAIN ANY PROBLEMS WITH ANESTHESIA OR UNUSUAL BLEEDING WITH PAST SURGERIES:

ARE YOU ALLERGIC TO:

___Penicillin	___Tetracycline	___Iodine	___Soybean	___Eggs
___Sulfites	___Erythromycin	___Sulfa drugs	_____Bacitracin	_____Keflex

LIST ANY KNOWN ALLERGIES TO OTHER MEDICATIONS NOT LISTED ABOVE:

LIST ALLERGIES TO FOODS, BEE STINGS, SKIN SENSITIVITIES, ETC.:

DO YOU HAVE HAYFEVER OR ENVIRONMENTAL ALLERGIES? YES NO
DO YOU RECEIVE ALLERGY SHOTS? YES NO

LIST CURRENT MEDICATIONS:

MEDICATION	DOSAGE	FREQUENCY	PURPOSE

Glenn W Jelks, MD and Elizabeth B Jelks, MD
TELEPHONE 212-988-3303 **FACSIMILE** 212-988-7984 875 PARK AVENUE NEW YORK, NY 10075 **WEB** WWW.JELKSMEDICAL.COM

NAME: _____ DATE: _____

DAILY ASPIRIN? YES NO DAILY VITAMIN E? YES NO

LIST ANY VITAMINS AND/OR NATURAL SUPPLEMENTS TAKEN REGULARLY:

CIRCLE ANY OF THE FOLLOWING THAT IS A PAST OR CURRENT DIAGNOSIS:

BLEEDING DISORDER HEPATITIS A OR B HIV/AIDS
TB (TUBERCULOSIS) HEPATITIS C LYME DISEASE

LIST ANY SERIOUS ILLNESS (PAST OR CURRENT):

HAVE YOU EVER HAD CHEMOTHERAPY? YES NO

HAVE YOU EVER HAD RADIATION THERAPY? YES NO

HAVE YOU HAD BOTOX ® (BOTULINIUM) INJECTIONS? YES NO

APPROXIMATELY HOW MANY TIMES? DATE OF LAST INJECTION
CIRCLE AREAS INJECTED
FOREHEAD NECK CROWS FEET LIPS OTHER_____

HAVE YOU HAD ANY OF THE FOLLOWING INJECTIONS TO YOUR FACE?

SILICONE RESTYLANE JUVEDERM SCULPTRA RADIESSE
PERLANE FAT OTHER_____

CIRCLE THE FOLLOWING PROCEDURES YOU HAVE HAD.

MICRODERMABRASION CHEMICAL PEEL LASER DEEP DERMABRASION THERMAGE

DO YOU HAVE ANY FACIAL IMPLANTS? YES NO

IF SO WHERE?

LIST ANY SPECIAL PRODUCTS USED ON YOUR FACE:

YOUR CURRENT HEALTH STATUS IS:

EXCELLENT GOOD FAIR POOR

HEIGHT_____ WEIGHT_____

DO YOU SMOKE? _____PACKS PER DAY **YES NO**

HAVE YOU EVER SMOKED? YES NO

IF SO, FOR HOW LONG? _____ IF YOU NO LONGER SMOKE, WHEN DID YOU QUIT? _____

DO YOU DRINK ALCOHOL?

BEER _____GLASSES PER DAY WINE_____GLASSES PER DAY SPIRITS_____GLASSES PER DAY

DO YOU CURRENTLY USE OR HAVE USED IN THE PAST ANY OF THE FOLLOWING?

MARIJUANA COCAINE HEROIN LSD METHADONE OTHER_____

HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CIRCLE)

COLD SORES HERPES SIMPLEX HERPES ZOSTER (SHINGLES)

IS THERE ANY POSSIBILITY YOU MIGHT BE PREGNANT? YES NO
IF APPLICABLE, WHEN WAS YOUR LAST MENSTRUAL PERIOD? _____

LIST YOU PRIMARY CARE PHYSICIAN:

NAME DATE OF LAST VISIT
ADDRESS

FOR PATIENTS CONTEMPLATING EYELID SURGERY, LIST YOUR OPHTHALMOLOGIST:

NAME DATE OF LAST VISIT
ADDRESS

ARE YOU CURRENTLY UNDER THE CARE OF A PSYCHIATRIST OR PSYCHOLOGIST? YES NO

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NAME: _____ **DATE:** _____

MARK ANY SYMPTOMS OR ILLNESSES YOU HAVE EXPERIENCED WHICH MAY HAVE A SIGNIFICANT IMPACT ON YOUR HEALTH:

General… ( ) Normal
___Recent weight loss
___Recent weight gain
___Fatigue

Mental... ( ) Normal
___Depression
___Anxiety/nervousness
___Trouble sleeping

Head… ( ) Normal
___ Migraine headaches
___ Tension headaches
___ Serious head Injury

Ears… ( ) Normal
___ Decreased hearing
___ Ringing
___ Balance trouble/vertigo

Eyes... ( ) Normal
___Wear glasses/contacts
___Dry eye
___Frequent itching/irritation
___Glaucoma
___Cataracts

Nose & Throat... ( ) Normal
___Nasal allergies
___Nose bleeds
___Difficulty breathing
___Nasal stuffiness
___Sinus infections
___Snoring
___Frequent sore throat

Mouth... ( ) Normal
___Dental problems
___Trouble chewing
___TMJ

Neck… ( ) Normal
___ Swollen glands
___ Enlarged thyroid

Endocrine... ( ) Normal
___Thyroid disease
___ Graves' disease
___ Diabetes

Heart... ( ) Normal
___High blood pressure
___Heart disease/attack
___Chest pain/angina
___Palpitations
___Irregular heart beat
___Mitral valve prolapse
___Echo performed
___Stress test performed

Digestive… ( ) Normal
___ Heartburn/ ulcer
___ Frequent nausea
___ Frequent diarrhea
___ Frequent constipation
___ Irritable bowel
___ History of Bleeding

Lungs... ( ) Normal
___ Asthma/Emphysema
___ Pulmonary embolus
___ Pneumonia
___ Tuberculosis
___ Shortness of breath

Liver...( ) Normal
___"Yellow" jaundice
___ Hepatitis
___ Elevated enzymes

Arms & Legs… ( ) Normal
___ Arthritis
___ Phlebitis/Vein thrombosis
___ Pulmonary embolism
___ Raynaud's phenomenon
___ Fibromyalgia

Back… ( ) Normal
___Back injury
___Recurrent pain

Urinary... ( ) Normal
___ Kidney stone
___ Difficulty urinating
___ Kidney/Bladder disease/infections

Neurological... ( ) Normal
___Easy fainting
___Seizure disorder
___Stroke
___Paralysis
___Bell's palsy

Bleeding... ( ) Normal
___Blood transfusion
___Anemia/thalassemia
___Easy bruising
___Excessive post-op bleeding

Skin... ( ) Normal
___ Skin cancer
___ Eczema
___ Psoriasis
___ Abnormal scars
___ Sun damage
___ Latex sensitivity

Immune Disorders( ) Normal
___ HIV/AIDS
___ Leukemia
___ Lupus
___ Lymphoma
___ Sarcoidosis
___ Scleroderma
___ Rheumatoid arthritis

LIST ANY *FAMILY HISTORY* OF SIGNIFICANT MEDICAL PROBLEMS THAT YOU THINK MAY BE IMPORTANT (E.G. HEART DISEASE, CANCER, DIABETES).

IS THERE A LEGAL MATTER RELATED TO THE PURPOSE OF YOUR VISIT? YES NO

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NAME: _____ DATE: _____

COMPLETE IF YOUR VISIT IS RELATED TO *EYELID SURGERY*

LIST ANY EYE DROPS OR OINTMENTS USED DAILY:

DO YOU HAVE FREQUENT ITCHING OR BURNING OF YOUR EYES?	YES	NO
DO YOU HAVE EPISODES OF EXCESSIVE TEARING?	YES	NO
DO YOU HAVE DRY EYE?	YES	NO
DO YOU USE TEAR MOISTURE DROPS / GEL FREQUENTLY? IF YES, HOW FREQUENTLY? _____	YES	NO
DO YOU USE OINTMENT IN YOUR EYES AT BEDTIME REGULARLY?	YES	NO
HAVE YOU EVER HAD A PLUG PLACED IN YOUR EYELID TO CORRECT DRY EYE?	YES	NO
HAVE YOU EVER BEEN TREATED FOR BLEPHARITIS?	YES	NO
HAVE YOU EVER BEEN TREATED FOR ROSACEA?	YES	NO
DO YOU HAVE GLAUCOMA?	YES	NO
DO YOU HAVE (OR HAVE HAD) DOUBLE VISION?	YES	NO
DO YOU HAVE A HISTORY OF CATARACT SURGERY?	YES	NO
DO YOU HAVE ANY PROBLEMS WITH THE RETINA OF YOUR EYE?	YES	NO
HAVE YOU EVER HAD HERPES INFECTION OF THE CORNEA?	YES	NO
HAVE YOU EVER HAD A SERIOUS INFECTION OR INFLAMMATION OF YOUR EYE?	YES	NO
HAVE YOU EVER HAD A SERIOUS INJURY TO:	EYE	EYELID
HAVE YOU EVER HAD SURGERY ON AN EYELID?	YES	NO
HAVE YOU EVER HAD STRABISMUS (EYEBALL MUSCLE) SURGERY?	YES	NO
HAVE YOU HAD REFRACTIVE SURGERY, eg, LASIK?	YES	NO
DO YOU WEAR CONTACT LENSES? SOFT OR HARD? _____ NUMBER OF YEARS _____	YES	NO
DO YOU HAVE POOR VISION IN EITHER EYE THAT IS NOT IMPROVED WITH GLASSES OR CONTACT LENSES?	YES	NO

DO YOU WEAR GLASSES FOR: DISTANCE VISION NEAR VISION BOTH

COMPLETE IF YOU HAVE *DROOPY OR HEAVY UPPER LIDS*

DO YOU HAVE HEAVY UPPER LIDS?	YES	NO
IS YOUR VISION DECREASED BY THE POSITION OF YOUR UPPER LIDS?	YES	NO
DO YOUR LIDS GET LOWER AS THE DAY PROGRESSES?	YES	NO
DO YOU EVER HAVE DISCOMFORT IN YOUR FOREHEAD?	YES	NO
DO YOU NEED TO USE YOUR FOREHEAD MUSCLES TO KEEP YOUR EYELIDS ELEVATED?	YES	NO
DO ANY FAMILY MEMBERS HAVE SIMILAR DROOPY UPPER LIDS?	YES	NO

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ONLY COMPLETE IF APPLICABLE

PRIMARY INS. COVERAGE:

SUBSCRIBER NAME: _____

RELATIONSHIP TO PT: _____ SELF _____ CHILD _____ SPOUSE _____ OTHER

INSURANCE COMPANY:_____

_____ _____

BENEFITS PHONE NUMBER (Include AREA CODE) PRE-CERT. PHONE NUMBER (Include AREA CODE)

CLAIMS ADDRESS:_____

_____

IDENTIFICATION #: _____ GROUP #: _____

OTHER (SPECIFY): _____

SECONDARY INS. COVERAGE:

SUBSCRIBER NAME: _____

RELATIONSHIP TO PT: _____ SELF _____ CHILD _____ SPOUSE _____OTHER

COMPANY:_____

_____ _____

BENEFITS PHONE NUMBER (Include AREA CODE) PRE-CERT. PHONE NUMBER (Include AREA CODE)

CLAIMS ADDRESS:_____

_____

IDENTIFICATION #: _____ GROUP #: _____

OTHER (SPECIFY): _____

INSURANCE AUTHORIZATION:

I hereby authorize Glenn W. Jelks, M.D., P.C. to furnish all information necessary including photographs to process my claim(s) for service(s) rendered from this date forward concerning my illness and treatment to all of my insurance carriers. Also, I consent to this consultation and treatment and further consent to the release of my medical records upon request.

INSURANCE ASSIGNMENT:

I hereby authorize payment of all medical benefits rendered to myself or my dependents to Glenn W. Jelks, M.D., P.C. and understand that I am responsible for all remaining balances not covered by my insurance carrier. A copy of this signed authorization can be accepted as an original.

_____

Signature of Patient/Guardian Date

ONLY COMPLETE IF APPLICABLE

Patient Name _____ Date _____

Dr. Glenn W. Jelks provides medical services and products as a private contractor. Medicare may not be billed for the services/products provided. You, the above named patient, are personally liable for all charges without limits that would otherwise be imposed by Medicare incurred to Glenn W. Jelks, M.D., P.C. Please review the Private Contract and sign below.

PRIVATE CONTRACT FOR MEDICARE BENEFICIARIES

1. Dr. Glenn W. Jelks has never been excluded from Medicare as an eligible physician.
2. Beneficiary or legal representative accepts full responsibility for payment of the charge for all services/products furnished.
3. Beneficiary or legal representative understands that Medicare limits do not apply to charges for all services/products furnished.
4. Beneficiary or legal representative understands that Medicare payment will not be made for any services/products furnished that would have otherwise been covered by Medicare if there were no private contract and a proper Medicare claim had been submitted.
5. Beneficiary or legal representative enters into the contract with the knowledge that he/she has the right to obtain Medicare covered products/services from other physicians who have not opted out of Medicare, and that the beneficiary is not compelled to enter into private contracts that apply to other Medicare covered services/products furnished by other physicians who have not opted out.
6. The effective date of the opt-out period is June 18, 2012 to June 18, 2014.
7. Beneficiary or legal representative understands that Medigap plans do not, and that other supplemental plans may elect not to, make payments for services/products not paid for by Medicare.
8. Beneficiary or legal representative enters into this contract for services that are not urgent.
9. Operating room charges for Jelks Medical Center are included in the private contract.
10. Beneficiary or legal representative agrees to reimburse physician for any costs and reasonable attorney fees that result from violation of this agreement by beneficiary or legal representative.

I have read the above contract and agree to the above statements. In addition, I agree not to bill Medicare or ask the physician to bill Medicare on my behalf.

Patient's Signature Date

Physician's Signature Date

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RECEIPT OF NOTICE OF PRIVACY PRACTICES

Attached is a copy of our *Notice of Privacy Practices,* which provide a detailed description of what we do with your health and personal information. This notice also explains your rights, as a patient, for obtaining access and controlling the use and disclosure of your information. Per HIPAA regulations, we are required to ask you to sign this *Receipt of Notice of Privacy Practice Form.* You have the right to refuse our request, in which case, we must document your refusal for the record. THANK YOU!

I acknowledge that I was provided my personal copy of Glenn W. Jelks, M.D., P.C.'s Notice of Privacy Practices to read and keep as my own.

_____ _____/_____/_____
Patient Name (Please Print) Patient's Date of Birth

RIGHTS AND RESPONSIBILITIES

1. You have the right to know that your information is shared with all necessary members of the staff.
2. You have the right to ask questions and be completely informed as to what care you are receiving.
3. You have the right to be involved in decision-making regarding your care.
4. You have the responsibility to inform the doctor/staff about medical conditions, allergies and or changes in medicine, in a timely manner, prior to treatment.
5. You have the responsibility to read the information provided to you and follow the instructions given by the doctor/medical staff to ensure the safety and success of your care.
6. These premises are protected with surveillance cameras, if the red light is on, the cameras are monitoring.

_____
Signature of Patient/Guardian Date

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Glenn W. Jelks, M.D., P.C. ("the practice") to use and disclose protected health information (PHI) about me to carry out treatment payment and healthcare operations (TPO). I have the right to review the Notice of privacy Practices prior to signing this consent.

I hereby give my consent to the Practice:

1. To call my home or other alternative location and leave a message on voice mail or in person on reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

2. To mail to my home or other alternative location any items that assists the practice in carrying out TPO, such as appointment reminder cards and patient statements.

3. To e-mail to my home or other alternative location any items that assists the practice in carrying TPO, such as appointment reminder cards and patient statements.

By signing this form, I am consenting to the Practice's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or it, the Practice may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Patient's Name Date

_____
Print Name of Patient or legal Guardian

AGREEMENT AS TO RESOLUTION OF CONCERNS

"I", "Patient/Guardian" shall be understood to mean _____
"Physician" shall be understood to mean Dr. Glenn W. Jelks and Glenn W. Jelks, M.D. PC.

Further, I understand that I am entering into a contractual relationship with Physician for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care to patients and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by the physician, I, the Patient/Guardian, agree not to initiate or advance, directly or indirectly, any meritless or frivolous claims of medical malpractice against the Physician.

Furthermore, should a meritorious medical malpractice case or cause of action be initiated or pursued, I (the patient) and/or my representative agree to use use American Board of Medical Specialties ("ASMS") board-certificed expert medical witness(es) in the same specialty as Physician. Furthermore, I agree that these expert witnesses will be members in good standing of the American Society of Plastic Surgery.

Finally, you (the patient) agree that counsel for me (Physician) shall have the right and be free to depose such expert witnesses at least 120 days before any scheduled trial date.

In futher consideration for this, I, (the Physician), agree to the same stipulations.

Patient/guardian and Physician acknowledge that monetary damages may not provide an adequate remedy for breach of this Agreement. Such breach may result in irreparable harm to Physician's reputation and business. Patient/guardian and Physician agree in the event of a breach to allow specific performance and/or injunctive relief.

_____ X_____
Physician Signature Patient/Guardian Signature

_____ X_____
Effective from Date of Treatment Date of Signature