HOUSTON OCULOFACIAL
PLASTIC SURGERY
MIRWAT S. SAMI, MD, FACS

PATIENT REGISTRATION FORM

Patient Name: _____ Date of Birth: ____/____/_____

Address_____ City _____ State_____ Zip Code_____

Cell Phone _____ Home phone _____ Work Phone _____

Date of Birth: _____/_____/_____ Social Security # _____- _____ -_____ Sex: Male / Female

Marital status ____ Single ____Married ____ Divorced ____ Widowed ____

Occupation_____

Email address _____ Driver's License number_____

Emergency Contact Name_____ Phone number_____

Referring Doctor _____ Phone number _____

Address _____ City_____ State _____ Zip Code_____

Family Doctor/Primary Care Physician _____ Phone number _____

Pharmacy Name and Location (street & city) _____

Primary Insurance-Insurance Company Name:_____

Group I.D. number_____

ID number_____

Plan name_____

Are you the insurance subscriber YES NO **If NO please list the following:**

First name of Subscriber_____ **Last name of Subscriber**_____

Date of Birth of Subscriber_____

Relationship to subscriber_____

Secondary Insurance-Insurance Company Name:_____

Group I.D. number_____

ID number_____

Plan name_____

Are you the insurance subscriber YES NO **If NO please list the following:**

First name of Subscriber_____ **Last name of Subscriber**_____

Date of Birth of Subscriber_____

Relationship to subscriber_____

PARENT /GUARDIAN INFORMATION (if patient is a minor)

Parent/ Guardian's Name _____

Address_____

Cell Phone( )_____Home phone( )_____ Work Phone( )_____

Relationship to Patient - Child _____ Other _____

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Patient Name: _____ **DOB:** _____ **Date:** _____

CC (onset, duration, severity, type, location, etc)

Allergies:	**Reaction**	**Severity**
_____	_____	mild / moderate / severe
_____	_____	mild / moderate / severe
_____	_____	mild / moderate / severe

Past Ocular History: (Please mark all that apply) □ No history of eye problems Other_____

□ Amblyopia (Lazy Eye) □ Diabetic Retinopathy □ Iritis/Uveitis
□ Astigmatism □ Dry Eye Syndrome □ Macular Degeneration _____
□ Cataracts □ Glaucoma
□ Corneal Disorder □ Retinal Detachment

Oculofacial Surgeries: (Please mark all that apply) □ No prior oculofacial surgery

R - L	**R - L**	**History of the following:**
□ □ Blepharoplasty (Lid Surgery)	□ □ Glaucoma Surgery	Botox
□ □ Cataract Surgery	□ □ Retinal Surgery	Fillers
□ □ Corneal Surgery	□ □ YAG Laser Capsulotomy	Other facial surgeries_____
□ □ LASIK	□ □ Strabismus (eye muscle surgery	_____

Other_____

Current Eye Medications: (Please list)_____
_____
_____

Other Medical History: □ No history of illnesses

□ Anemia	□ Headache	□ Liver Disease
□ Arthritis	□ Hearing Loss	□ Lupus
□ Arrhythmia	□ Heart Attack	□ Migraine
□ Asthma	□ Hepatitis	□ Multiple Sclerosis
□ Cancer	□ Herpes	□ Polymyalgia Rheumatica
□ Congestive Heart Failure	□ High Blood Pressure	□ Psychiatric Disorder
□ COPD	□ High Cholesterol	□ Rheumatoid Arthritis
□ Diabetes (circle: Type 1 or Type 2)	□ HIV/AIDS	□ Stroke
□ Fibromyalgia	□ Kidney Disease	□ Thyroid Disease

Other_____

General Surgeries/Procedures: (Please list with dates)

_____

_____

All Other Medications: (Please list)_____

_____

_____

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Family History: (Please indicate relationship) □ No history of illnesses □ History unknown

□ Blindness
□ Cancer
□ Cataracts
□ Diabetes
□ Glaucoma
□ Heart Disease
□ High Blood Pressure
□ Lazy Eye
□ Macular Degeneration
□ Retinal Disease
□ Stroke
□ Other_____

Social History: (Please mark all that apply)

Smoking: □ current every day smoker □ current some day smoker □ former smoker □ never smoked

Alcohol Use: □ No □ Yes If yes, how much and how often?_____

Drug Use: □ No □ Yes If yes, which and how long?_____

Review of Systems: (Please mark all that apply)

Eyes
- □ Previous Surgery
- □ Contact Lens
- □ Pain
- □ Double Vision
- □ Glaucoma
- □ Cataracts
- □ Macular Degeneration
- □ Dry Eyes
- □ Flashes
- □ Floaters

Ear, Nose, and Throat
- □ Hard of Hearing
- □ Ringing in Ears
- □ Vertigo

Cardiovascular
- □ Chest Pain
- □ Dizziness
- □ Fainting Spells
- □ Shortness of Breath
- □ Irregular Heart Beat
- □ Difficulty Lying Flat

Constitutional
- □ Fatigue / Weakness
- □ Fever
- □ Weight Gain / Loss

Respiratory
- □ Cough
- □ Congestion
- □ Wheezing
- □ Asthma

Gastrointestinal
- □ Heartburn
- □ Nausea / Vomiting
- □ Jaundice / Hepatitus

Genitourinary
- □ Pain / Difficulty
- □ Blood in Urine
- □ History of Kidney Stones
- □ History of STD's

Psychiatric
- □ Anxiety / Depression
- □ Mood Swings
- □ Difficulty Sleeping

Endocrine
- □ Increased Thirst
- □ Increased Hunger
- □ Increased Urination
- □ Increased Sweating
- □ Fingernail Changes

Blood/Lymph Nodes
- □ Easy Bruising
- □ Gums Bleed Easy
- □ Prolonged Bleeding
- □ Heavy Aspirin Use

Musculoskeletal
- □ Stiffness
- □ Arthritis
- □ Joint Pain / Swelling

Skin
- □ Rash / Sores
- □ Lesions
- □ Hives / Eczema

Neurological
- □ Seizures
- □ Weakness / Paralysis
- □ Numbness
- □ Tremors

Immunologic
- □ Hives
- □ Itching
- □ Runny Nose
- □ Sinus Pressure

Vision: Near

VAcc OD _____ **sc OD _____**

Vacc OS _____ **sc OS _____**

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Patient Acknowledgement Form

Our "Notice of Privacy Practices" provides information about how we may use and disclose protected health information (PHI) about you. It applies to the information and records we have about your health, health status, and the health care and services you receive at this office. The date of the most recent Notice will appear in the upper right hand corner. By signing this form, you are simply acknowledging that you have been offered or have received a copy of our "Notice of Privacy Practices."

_____ _____

Patient's Signature Date

Do you wish to have our office call to confirm your appointments? YES ☐ NO ☐

May we leave a message if no answer? YES ☐ NO ☐

May we contact you via email? YES ☐ NO ☐

I consent to receive text messages sent through an automatic telephone dialing system. I understand that I will always have the ability to opt-out if I decide that I no longer want to receive texts from this practice. YES ☐ NO ☐

_____ _____

Patient's Signature Date

Access to Patient Information

I give permission for the following people to have access to my Protected Health Information.

Name(s)/Relationship _____

_____

_____ _____

Patient's Signature Date

I understand that this consent can be revoked at any time except to the extent that disclosure made in good faith has already occurred in reliance on this consent. The revocation must be in writing and delivered to Houston Oculofacial Plastic Surgery.