

Kim Kirchgessner Maale, M.D., P.A. Eye Plastics Plano
3108 Midway Rd Suite 106 Plano TX 75093
972.608.0359

Today's Date: _____

Patient's Name: _____ M ___ F ___ DOB _____

Age _____ Marital Status _____ Social Security # _____

Address _____ Your Occupation _____

City _____ Zip _____ Your Employer _____

Home # (____) _____ Msg. Ok? ___ Spouse's Name _____

Work # (____) _____ Msg. Ok? ___ Spouse's DOB _____

Cell # (____) _____ Msg. Ok? ___ Referred by _____

E-mail _____

Primary Care Physician _____ Date of last visit _____

PCP Phone Number _____ Date of last EKG _____

Pharmacy: _____ Pharmacy # _____

Please list the family members or other persons whom we may contact in an emergency.

Name: _____ Tel# _____

Relationship? _____

**Please initial if this is someone you also want informed about your general medical condition and your diagnosis (including treatment, payment and healthcare options): _____

Primary Insurance _____ **Secondary Insurance** _____

Policy Number _____ Policy Number _____

Group Number _____ Group Number _____

Insured _____ Insured _____

DOB of Insured _____ DOB of Insured _____

SS# _____ SS# _____

Relationship to Patient _____ Relationship to patient _____

Medical History: Review of Systems

Patient's Name: _____ DOB: _____

What medical problem(s) are you being treated for? Who are your doctors?

Illness/condition	Doctor	Phone
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you had any surgeries in the past? (please include cosmetic procedures)	Date	Doctor	Complications
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever had a blood transfusion: Y___ N___ When? _____

Allergies: **PLEASE CIRCLE** : Penicillin Sulfa Iodine Shellfish Latex Codeine

Other: **(please list)** _____

Please Circle any of the following medications you take regularly or occasionally

- | | | | |
|----------------------|----------------|-------------------|-------------------------|
| Aspirin | Coumadin | Plavix | aleve/naproxen |
| Other blood thinners | st john's wart | Celebrex | glucosamine/chondroitin |
| Ginko biloba | vitamin e | motrin/ibuprofen | fish/flax seed oil |
| Cinnamon | turmeric | tart cherry juice | Xarelto |

Please list all other medicines (prescription and non-prescription):

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any eye disease, eye injuries or surgeries (i.e. LASIK) and approximate date & eye doctor:

Family History

Please list family members who have these conditions:

Cancer _____ Heart Disease _____ Diabetes _____
 Glaucoma _____ Eye Diseases _____

Patient Medical History: Review of Systems

Patient's Name: _____ DOB: _____

CARDIOVASCULAR

HIGH BLOOD PRESSURE Y__N__
HEART FAILURE Y__N__
HEART ATTACK Y__N__ Date: _____
ANGINA Y__N__
HEART MURMUR Y__N__
BYPASS SURGERY Y__N__ Date: _____
PACEMAKER Y__N__ Date: _____
DO YOU EXERCISE? Y__N__
LAST EKG _____
IRREGULAR HEARTBEAT Y__N__
HIGH CHOLESTEROL Y__N__

NEUROLOGICAL

STROKE Y__N__ Date: _____
SEIZURES Y__N__ Date: _____
FAINTING Y__N__
DIZZINESS Y__N__
HEADACHES Y__N__
DOUBLE VISION Y__N__

ENDOCRINE

DIABETES Y__N__ last A1C: _____
THYROID DISEASE Y__N__
TAKEN STEROIDS Y__N__

PSYCHIATRIC

PSYCHIATRIC CARE Y__N__
DEPRESSION Y__N__
ANXIETY Y__N__
OCDS Y__N__

HEMATOLOGY/ONCOLOGY

CANCER Y__N__ Type: _____
RADIATION THERAPY Y__N__ When: _____
SKIN CANCER Y__N__ Type: _____
MELANOMA Y__N__ Where: _____
BLEEDING TENDENCY Y__N__
EASY BRUISING Y__N__
SICKLE CELL DISEASE Y__N__
BLOOD CLOTS IN LEGS Y__N__
BLOOD CLOTS IN LUNGS Y__N__

STAPH INFECTION Y__N__
HIV Y__N__ titers: _____

URINARY/REPRODUCTIVE

KIDNEY DISEASE Y__N__
DIALYSIS Y__N__
URINARY PROBLEMS Y__N__

GENERAL HEALTH

DO YOU HAVE TATTOOS Y__N__
DO YOU SMOKE Y__N__
HOW MUCH? _____ HOW LONG? _____
HAVE YOU EVER SMOKED Y__N__
HOW MUCH? _____ HOW LONG? _____
DO YOU CONSUME ALCOHOL Y__N__
HOW OFTEN? _____
DO YOU USE RECREATIONAL DRUGS? Y__N__
DESCRIPTION: _____

RESPIRATORY

ABNORMAL CHEST XRAY Y__N__
ASTHMA Y__N__
BRONCHITIS Y__N__
EMPHYSEMA Y__N__
SHORTNESS OF BREATH Y__N__
COUGH Y__N__
SLEEP APNEA Y__N__
USE A C-PAP MACHINE Y__N__

MUSCULOSKELETAL

NECK/BACK/ LEG PROBLEMS Y__N__
SCIATICA Y__N__
HERNIATED DISC Y__N__
ARTHRITIS Y__N__

INFECTIOUS/GI/LIVER

HEPATITIS Y__N__
JAUNDICE Y__N__
LIVER DISEASE Y__N__
HIATAL HERNIA Y__N__
ULCERS Y__N__
HEARTBURN Y__N__

EYES

CATARACTS Y__N__
GLAUCOMA Y__N__
HERPES SIMPLEX Y__N__
FEVER BLISTER ON EYE Y__N__
SHINGLES Y__N__

OTHER: _____
DATE OF LAST EYE EXAM _____
NAME OF EYE DOCTOR: _____

HEIGHT: _____
WEIGHT: _____

Kim K. Maale, MD PA
3108 Midway Rd Ste 106
Plano, TX 75093

NOTICE TO PATIENTS
DISCLOSURE OF PHYSICIAN OWNERSHIP

Please review carefully the information contained in this notice.

1. During the course of our physician/patient relationship, I may refer you to Physician Medical Center, LLC. dba Texas Health Center for Diagnostics & Surgery Plano ("Hospital") or one or more other physicians who provide specialized medical services.
2. I want to inform you that I am very aware of the services provided at this Hospital because I have an ownership interest in it. Further, if I refer you to another physician for specialized medical services that physician also could have an ownership interest in the Hospital.
3. I am providing this information to help you make an informed decision about your health care. You have the right to choose your health care provider. Therefore, you have the option to use a health care facility other than the Hospital or physicians to whom I might refer you from time to time.
4. I will not be treating you differently if you choose to obtain health care at a facility other than the Hospital and, if you desire, I will be happy to provide you information about alternative health care providers.

If you have any questions, please do not hesitate to ask. We welcome you as a patient, and we value our relationship with you.

By signing below you acknowledge that you have read and understand this notice, and that you are aware of my ownership interest in the Hospital. Should you be referred to the Hospital or to another physician who holds an ownership interest in the Hospital, you acknowledge your decision to decline the option to have your health care provided at another health care facility. You further acknowledge that you signed this notice prior to my referral of you to the Hospital or another physician.

Printed Name: _____ Date: _____

Signature of Patient: _____

Signature of Parent or Guardian:

(if applicable)

HIPPA Laws Acknowledgement & Financial Policy

We have adopted the following financial policies to avoid confusion and misunderstandings.

1. We will file only on insurance that we are contracted with. At your appointment, please provide your driver's license and insurance card(s). If your insurance requires a physician referral, it is your responsibility to obtain it and ensure that our office has received it.
2. I hereby assign all medical and/or surgical benefits to which I am entitled, including all insurance plans, for charges incurred at the office or surgery center to Dr. Kim Kirchgessner Maale, M.D., P.A. for services rendered.
3. I hereby authorize Kim Kirchgessner Maale, M.D., P.A. to release my medical records to my insurance company if needed to secure payment. I authorize release via fax and authorize a copy of this release to be considered as valid as an original. This release will remain in effect until revoked by me in writing.
4. We collect payment at the time of service. Copays/deductible for surgery are pre-collected at your pre-op appointment. We collect based upon the information provided by insurance. Amount collected is an estimate. Patient final responsibility will be determined when your insurance has processed your claim. If we are not contracted with your insurance, the charges for your care are your responsibility. **Your insurance is an agreement between you and your insurance company. Payment of your account is your responsibility.** If we have not received payment from your insurance after 60 days, payment becomes your responsibility.
5. In the event a service is "not covered" by your insurance, you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
6. During peak surgery times, a **\$1000.00 non-refundable** deposit will be required in order to book cosmetic surgery during these times. During non-peak surgery times a **\$500.00 non-refundable** deposit is required. A **\$250.00** rescheduling fee may be charged for any rescheduled surgical procedures.
7. There may be a **\$250.00** charge for cancellation of any surgical procedures.
8. All appointments must give 24 hour notice of cancellation or there will be a **\$25.00** charge billed to the patient. There will be a **\$25.00** charge for all account balances not paid within 30 days of billing, returned checks, forms needing to be signed by doctor (including FMLA) or to copy and release medical records (by mail or fax). We require a written request to release records to anyone, other than the referring ophthalmologist, insurance company or a Physician Dr. Maale refers, and will require at least 5 working days to process request.

Minor Patients: For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment. We must also have permission from the legal guardian in order to examine the patient. Parent/guardian must be present during all examinations.

By signing below, I acknowledge receipt of the Notice of Privacy Rights and HIPPA Laws and give my permission to Kim Kirchgessner Maale, M.D., P.A. to use and disclose my health information in accordance with it. I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

Printed Name of the Patient

Signature of Patient or Responsible Party if a Minor

Date