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

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)

Kim Kirchgessner Maale, M.D., P.A.

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-refunable** 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