Please arrive 15 minutes prior to your new patient appointment

Advanced Eyelid Surgery Center

Mayli Davis, M.D.

817-329-4480

Patient Information

Today's Date:_____

Please complete all of the following legibly.

Name: _____ Social Security #: _____ Birth Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Preferred Contact Number: Home Cell Work Primary # to be reached _____

Cell # _____

Age: _____ Sex: Male Female Marital Status: S M W D Ethnicity: ☐ Caucasian ☐ Hispanic ☐ African American ☐ Native American ☐ Other _____

Primary Language: _____

E-Mail: _____ Employer: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

Referring Physician: _____ Phone #: _____

Primary Care Physician: _____ Phone #: _____

Insurance Information

Name of Primary Insurance Carrier: _____ ID#: _____

Group #: _____ Type: ____ HMO ____ PPO ____ Other _____

Name of Secondary Insurance Carrier: _____ ID#: _____

Group #: _____ Type: ____ HMO ____ PPO ____ Other _____

Person responsible for Insurance

Name: _____ Social Security #: _____ DOB: _____

Relationship to patient: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Name of Employer: _____ Work #: _____

I here by assign payment directly to Mayli Davis, M.D. for medical and surgical services rendered to my self or my dependents. I understand I am financially responsible for any charges not covered by this assignment. I also authorize Mayli Davis, M.D. to release any information in the course of my examination or treatment for insurance purposes or medical treatment.

Photos: During the course of treatment, Mayli Davis, M.D. may take photos. Some insurance companies do not cover this service. In that event I agree to pay $20.00 for this service. Initials _____

_____ _____

Signature Date

Do you currently have any of the following problems? If yes, please explain:

Diabetes ..... ☐ yes ☐ no _____
Thyroid ..... ☐ yes ☐ no _____
Unexpected weight loss/gain ..... ☐ yes ☐ no _____
Heart disease ..... ☐ yes ☐ no _____
- High blood pressure ..... ☐ yes ☐ no _____
- Pace maker, bypass surgery ..... ☐ yes ☐ no _____
- Congestive failure, heart attack .... ☐ yes ☐ no _____

Lung disease ..... ☐ yes ☐ no _____
- Asthma, emphysema ..... ☐ yes ☐ no _____
- Tuberculosis ..... ☐ yes ☐ no _____
- Shortness of breath ..... ☐ yes ☐ no _____

Stomach problems ..... ☐ yes ☐ no _____
- Ulcers ..... ☐ yes ☐ no _____
- Abdominal pain ..... ☐ yes ☐ no _____

Urinary problems ..... ☐ yes ☐ no _____
- Pain or discomfort ..... ☐ yes ☐ no _____
- Kidney stones ..... ☐ yes ☐ no _____
- Blood in urine ..... ☐ yes ☐ no _____

Skin problems ..... ☐ yes ☐ no _____
- Changes in skin color ..... ☐ yes ☐ no _____

Bleeding trouble ..... ☐ yes ☐ no _____
Blood transfusion ..... ☐ yes ☐ no _____
Hearing loss ..... ☐ yes ☐ no _____
Sinus problems ..... ☐ yes ☐ no _____
Muscle weakness ..... ☐ yes ☐ no _____
Arthritis ..... ☐ yes ☐ no _____
Psychiatric problems ..... ☐ yes ☐ no _____
Neurologic problems ..... ☐ yes ☐ no _____
- Paralysis ..... ☐ yes ☐ no _____
- Numbness or tingling ..... ☐ yes ☐ no _____
- Headache ..... ☐ yes ☐ no _____

• List other disorder or medical conditions not noted above _____

_____

Patient's signature: _____ Date: _____

Physician's Signature: _____ Date: _____

Mayli Davis, MD
ADVANCED EYELID SURGERY CENTER

PATIENT HISTORY RECORD

Name: _____ Age: _____ Date: _____

Today's complaint: _____

Have you ever had any eye surgery, laser or injury? ☐ yes ☐ no If yes, list when and what type:

_____

List all eye drops: _____

List all medications: _____

_____

Pharmacy Name:_____ Address:_____ Phone #:_____

Are you taking any aspirin products? ☐ yes ☐ no

Please list any non-prescription drugs or vitamins you are using: _____

_____

Are you allergic to any medications? Please list: _____

Are you current with your immunizations? ☐ yes ☐ no Date of last tetanus: _____

List any surgery: _____

Hobbies/interest: _____

If retired, list previous occupation(s) _____

Have you ever smoked? ☐ yes ☐ no quit when? _____

Drink alcohol? ☐ yes ☐ no If yes, how much in a typical day? _____

Use illegal drugs? ☐ yes ☐ no

Do you have or do you have a <u>family</u> history of:

	SELF		FAMILY			SELF		FAMILY	
Blindness	☐yes	☐no	☐yes	☐no	Macular degeneration	☐yes	☐no	☐yes	☐no
Glaucoma	☐yes	☐no	☐yes	☐no	Retina detachment	☐yes	☐no	☐yes	☐no
Vision Loss	☐yes	☐no	☐yes	☐no	Amblyobia(lazy eye)	☐yes	☐no	☐yes	☐no
Cataracts	☐yes	☐no	☐yes	☐no	Inflammation of eyes	☐yes	☐no	☐yes	☐no

If yes, please explain: _____

_____

Health status of parents, siblings and/or children or cause of death: _____

_____

OVER →