NORTH TEXAS OPHTHALMIC PLASTIC SURGERY
MARK ALFORD, MD/ MATTHEW HAMMONS, MD

Date: _____

(Please Print)

Male ☐
Female ☐

PATIENT INFORMATION

Patient's Name _____Spouse's Name_____

Mailing Address _____ APT # _____

City, State, Zip_____ Home Phone (_____)_____

Date of Birth _____ Age _____SS#_____ Alt. Phone (_____)_____

Primary Care Physician: _____Telephone: (_____)_____

Referred By: _____ Telephone: (_____)_____

In Emergency, contact: _____ Phone: (_____)_____
Relationship:_____

Primary Insurance Co_____ Policy#_____
Group#_____ Policy Holder _____ Policy Holder DOB_____
Policy Holder SS#_____ Relation to Patient _____ Policy Holder Employer _____

Secondary Insurance Co_____ Policy#_____
Group#_____ Policy Holder _____ Policy Holder DOB _____
Policy Holder SS#_____ Relation to Patient _____ Policy Holder Employer _____

PHOTOGRAPHY CONSENT

I hereby authorize photographs to be taken for medical purposes. I agree to the use of the negatives, prints, copies or reproductions for insurance documentation, teaching, surgical facilities and for monitoring my condition.
I hereby release and discharge the physician and his representatives from any and all claims and demands arising out of or in connection with the use of the photographs including any and all claims of libel.

X_____ _____
PATIENT, PARENT/ GUARDIAN DATE

MEDICAL TREATMENT: I authorize and request examination by the doctors or their staff. I authorize the performance of whatever procedures the judgment of the above named staff may deem necessary during treatment. I also authorize the administration of any anesthetics and analgesics (including eye drops) which they deem advisable. I may request that any procedure not be performed. I understand that I am undergoing a specialized exam of the eyelids and orbits in which most cases a complete eye exam will not be performed.

ASSIGNMENT OF BENEFITS: I authorize payment directly to North Texas Ophthalmic Plastic Surgery of the surgical and/or medical insurance benefits for services of Mark Alford, MD/ MD/Matthew Hammons, MD. I also authorize the doctors and their staff to provide information to my insurance company directly pertaining to relevant claims.

MEDICARE BENEFITS: I request that payment of authorized Medicare benefits be made to North Texas Ophthalmic Plastic Surgery for any medical service furnished to me. I authorize any holder of medical information about me to release to Centers for Medicare and Medicaid and its agents any information needed to determine these benefits of the benefits payable for related services.

Read and Acknowledged: _____ _____
PATIENT, PARENT/ GUARDIAN DATE

NORTH TEXAS OPHTHALMIC PLASTIC SURGERY Date: _____
MARK ALFORD, MD/ MATTHEW HAMMONS, MD
Patient Medical Questionnaire

(Please Print)

Patient Name: _____ **Date of Birth**: _____

Medications the patient is taking (including eye drops, vitamins, and herbal supplements):

Medications	**Dosage**	**How often taken?**

Allergies to Medications: **Yes_____** **No_____**

Please list: _____

History of Eye Problems:

Please Check	**Yes**	**No**
Previous Eye Injury	___	___
Has one eye ever crossed or turned out?	___	___
Previous Eye Surgery	___	___
Glaucoma	___	___
Retinal Detachment	___	___
Cataracts	___	___

Medical History:

Please Check	**Yes**	**No**
Asthma or Allergy	___	___
Diabetes	___	___
Heart Disease	___	___
High Blood Pressure	___	___
Arthritis	___	___
Cancer	___	___
Stroke	___	___
GI Problems	___	___

History of Surgeries:

Procedure	**Date**	**Surgeon**

_____ _____

Signature of Patient Date