Consultants in Ophthalmic & Facial Plastic Surgery

Diplomates, American Board of Ophthalmology
Fellows, American Academy of Ophthalmology
Fellows, American Academy of Cosmetic Surgery

Frank A. Nesi, MD, FACS, FAACS
Geoffrey J. Gladstone, MD, MSE, FAACS
Evan H. Black, MD, FACS, FAACS
Francesca D. Nesi-Eloff, MD
Dianne M. Schlachter, MD
Francisco Castillo, MD

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(734) 655-0672

FAX 248.746.0683
www.facialworks.com

WELCOME TO OUR PRACTICE!

We look forward to seeing you. Our mission is excellence in clinical care and customer service. Please contact us at **248-357-5100** if we can be of assistance.

We have scheduled an appointment for:

_____

to see Doctor Nesi, Gladstone, Black, Nesi-Eloff, Schlachter, or Castillo in our:

_____ office.

Please see the attached map for our address and directions.

_____

(Day) (Date) (Time)

PLEASE NOTE THIS APPOINTMENT IS FOR A CONSULTATION ONLY. Additional treatment and/or surgery, if needed, will be determined by the doctor and scheduled separately.

We ask that you arrive fifteen (15) minutes before your scheduled appointment to streamline the new patient registration process. To help us meet your entire healthcare needs, **please fill out the enclosed forms completely and bring them with you to your appointment.** To allow yourself and the doctor enough time for this consultation, be prepared to spend up to two (2) hours in our office.

If you are a contact lens wearer, please bring your contact lens case, solution, and glasses as we may ask you to remove your lenses for this consultation.

You are responsible for your office visit and/or consultation fee. If you have health insurance coverage, please bring all medical insurance cards and forms necessary for us to bill your insurance. If you do not have this coverage please be prepared to pay the day of your appointment. We accept cash, check, Visa, MasterCard, Discover, and American Express

If you are enrolled in a managed care health plan (HMO), you will need a referral or authorization from your Primary Care Physician (PCP) prior to your appointment in our office. If authorization is not obtained, you will be responsible for the bill.

Please be sure to list all of your medications (both prescription and over-the counter) with dosages, as well as any supplements you take on the attached "Medication List" and bring it with you to your appointment.

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PATIENT INFORMATION SHEET

Please print the following information. All information given will remain strictly confidential. If you need any assistance in completing this form please ask we will be happy to assist you.

PERSONAL INFORMATION:

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

Address: _____ **City:** _____ **State:**___ **Zip:**_____

Home Phone: (____) _____ **Cell Phone:** (____) _____

Email Address: _____

Social Security No: _____-_____-_____ **Gender: (Please circle one) Male / Female**

(Circle one): Married: Spouse's Name_____ **Divorced / Single / Widowed / Other**

Alternate Contact: _____ **Relationship:**_____

Alternate Contact Phone No: (____) _____

Insurance Information: (Please fill out if the PATIENT is NOT the main cardholder of the primary, secondary or tertiary insurance)
Name: _____ **Relation:** _____
Date of Birth_____ **Social Security No.:**_____-_____-_____
Address: (Only if differs from the patient): _____
City: _____ **State:** _____ **Zip:** _____ **Phone:** (____) _____

Employment: Retired: Yes / No
Employer Name: _____ **Phone:** (____)_____
May we contact you at work? Yes / No

Referring Physician: _____ **Phone:** (____) _____
Address: _____ **City:**_____ **State:** _____ **Zip:** _____
Primary Care Physician/Internist (If different from referring Doctor)
Name: _____ **Phone:** (____) _____
Cardiologist Name: _____ **Phone:** (____)_____

Workers' Compensation or Automobile accident related? Yes / No
Name of Company: _____ **Phone:** (____) _____
Address: _____ **City:** _____ **State:**_____ **Zip:** _____
Policy Holder: _____ **Agent Name:** _____
Case / Claim No: _____ **Date of Accident / Injury:** _____

I hereby certify that all the information given above is true and accurate to the best of my knowledge.

SIGNED: _____ **Date:** _____
(Patient, parent of minor or legal representative)

Patient Info:

Height _____

Weight _____

HISTORY AND EVALUATION

PRE-ANESTHESIA HISTORY - PLEASE CHECK either YES or NO

1. Are you allergic to any medications? Which ones?	❑ YES	❑ NO
2. Do you regularly take prescription drugs/vitamins/aspirin? If yes, please list on medication list provided.	❑ YES	❑ NO
3. Have you ever had any type of anesthesia in the past?	❑ YES	❑ NO
Were there any problems?	❑ YES	❑ NO
Has anyone in your family ever had problems?	❑ YES	❑ NO
4. Have you ever had an operation? If yes, please list with approximate dates.	❑ YES	❑ NO
5. Are there eye or medical problems that run in your family? If yes, please describe.	❑ YES	❑ NO

MEDICAL HISTORY - Please check either YES or NO

YES	NO		COMMENTS ONLY
❑	❑	HIGH BLOOD PRESSURE	
❑	❑	HEADACHES	
❑	❑	HEART TROUBLE	
❑	❑	RHEUMATIC FEVER OR HEART MURMUR	
❑	❑	CHEST PAIN	
❑	❑	SHORTNESS OF BREATH OR COUGH	
❑	❑	BRONCHITIS OR EMPHYSEMA	
❑	❑	ASTHMA	
❑	❑	TUBERCULOSIS OR PNEUMONIA	
❑	❑	DO YOU SMOKE? HOW MUCH?	
❑	❑	HEPATITIS OR JAUNDICE	
❑	❑	DIABETES	
❑	❑	HIATAL HERNIA	
❑	❑	STROKE	
❑	❑	SEIZURE (FITS)	
❑	❑	SCIATICA OR BACK PROBLEMS	
❑	❑	KIDNEY DISEASE	
❑	❑	THYROID DISEASE OR GOITER	
❑	❑	ARTHRITIS	
❑	❑	ANEMIA OR SICKLE CELL DISEASE	
❑	❑	BLEEDING OR CLOTTING PROBLEMS	
❑	❑	PHLEBITIS	
❑	❑	BLOOD TRANSFUSIONS	
❑	❑	DO YOU DRINK ALCOHOL? HOW MUCH?	
❑	❑	RECENT COLD OR SORE THROAT?	
❑	❑	DO YOU FEAR BEING IN AN ENCLOSED OR CONFINED AREA?	
❑	❑	DO YOU HAVE CAR, AIR, OR SEA SICKNESS?	
❑	❑	DO YOU HAVE A HISTORY OF DRUG ABUSE?	
❑	❑	DO YOU HAVE ANY LOOSE, FALSE OR CAPPED TEETH?	
❑	❑	FOR FEMALES ONLY: ARE YOU PREGNANT NOW? WHICH MONTH?	

VERIFIED: _____

_____

_____

_____

PATIENT'S SIGNATURE _____

TECH/NURSE SIGNATURE _____

DATE _____

MEDICATION LIST DATE:

Patient Name:	Allergies:

START DATE	MEDICATION/VITAMINS/HERBAL SUP/ASPIRIN	DOSAGE/DIRECTION/AMOUNT

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Dear Patient,

In addition to the medical procedures offered by our practice, we also offer a number of appearance enhancing cosmetic procedures and products (Listed Below). Please check any of the below for which you would like more information at your visit:

□ ***Upper and Lower Eyelid Blepharoplasty***
(Plastic surgery of the eyelids)

□ ***Endoscopic Brow and Forehead Lifting***

□ ***Laser Skin Resurfacing (for lines or wrinkles of the face)***

□ ***Facial Fillers (such as Restylane™/Juvederm™/Radiesse™)***

□ ***BOTOX™ (for lines or wrinkles of the forehead)***

□ ***Latisse™ (eyelash enhancer)***