Frank Nesi, MD | Geoffrey Gladstone, MD | Evan Black, MD | Francesca Nesi-Eloff, MD
Dianne Schlachter, MD | Robert Beaulieu, MD | Alon Kahana, MD
Lindsay El-Awadi, PA-C | Sara Turner, PA-C

Comerica Tower
29201 Telegraph Road
Suite 324
Southfield, MI 48034
248-357-5100

21000 Twelve Mile Road
Suite 108
St. Clair Shores, MI 48081
586-447-5570

75 Barclay Circle
Suite 105
Rochester Hills, MI 48307
248-852-8931

19853 West Outer Drive
Suite 102
Dearborn, MI 48124
313-562-5034

2401 West Big Beaver Road
Suite 101
Troy, MI 48084
248-457-0596

26850 Providence Parkway
Suite 420
Novi, MI 48374
248-344-7888

2353 South Linden Road
Suite C
Flint, MI 48532
810-733-3556

15356 Trenton Road
Southgate, MI 48195
734-258-7400

36650 Five Mile Road
Suite 100
Livonia, MI 48154
734-655-0672

FAX 248-746-0683
TheEyelidExperts.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, or Schlachter 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. You will also need to have your insurance card and a photo I.D. at the time of your visit or your appointment must be rescheduled. If you have an authorized representative please bring proof the day of 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, consultation fee and/or insurance deductible which are collected at registration. 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

Please note: We charge a $50 cancellation fee for any missed or late cancelled appointments. To cancel an appointment please call no later than 24 hours, prior to your scheduled appointment. If your appointment is on a Monday, please call no later than 2:00 PM Friday.

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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CONFIDENTIAL PATIENT INFORMATION SHEET - (PLEASE PRINT)

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: (____) _______________

Referring Physician: _______________________________ Phone: (_____) ___________________
Address: ________________________________ City:_______________ State: ______ Zip: ________
Primary Care Physician/Internist (If different from referring Doctor)
Name: _____________________________________ Phone: (_____) __________________________
Cardiologist Name: ____________________________ Phone: (_____) __________________________

Preferred Pharmacy:
Name of Pharmacy: ____ Phone: (____) ______________
Address: _________________________________ City: ______________ State:_______ Zip: _______

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

Workers' Compensation or Automobile accident related? Yes / No

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)

HISTORY AND EVALUATION

Patient Name : ____ Date of Birth: _____ / ______ / _______

Height: _________ Weight: _________ Date of Last Dilated Eye Exam: _______________________________

EYES

Yes	No	
☐	☐	Glasses
☐	☐	Contacts ☐ Soft ☐ Hard
☐	☐	Glaucoma
☐	☐	Dry Eye
☐	☐	Punctal Plugs
☐	☐	Cataracts
☐	☐	Strabismus
☐	☐	Macular Degeneration
☐	☐	Recent Fillers and/or Botox Location: ________________________
☐	☐	Facial Trauma - Type: ________________________
☐	☐	Thyroid Eye Disease
☐	☐	Oculopharyngeal Muscular Dystrophy
☐	☐	Ocular Cicatricial Pemphigoid (OCP)
☐	☐	Previous Eye, Eyelid, and / or Tearing Surgery – Type: ________________________

EARS, NOSE & THROAT

Yes	No	
☐	☐	Limited Mouth / Neck Motion
☐	☐	TMJ History
☐	☐	Dentures
☐	☐	Ringing in Ears
☐	☐	Deviated Septum
☐	☐	Chipped / Loose Teeth
☐	☐	Chronic Sinus Infections
☐	☐	Previous Sinus Surgery

ENDOCRINE

Yes	No	
☐	☐	Diabetes - # of Years: ______ ☐ Type 1 ☐ Type 2
☐	☐	Insulin Dependent
☐	☐	Non-Insulin
☐	☐	Diet Controlled
☐	☐	Hyperthyroid
☐	☐	Hypothyroid

HEART

Yes	No	
☐	☐	High Blood Pressure
☐	☐	Angina
☐	☐	Chest Pain
☐	☐	Congestive Heart Failure
☐	☐	Bypass
☐	☐	Stents
☐	☐	Mitral Valve Prolapse
☐	☐	Heat Murmur
☐	☐	Arrythmia
☐	☐	Atrial-fibrillation
☐	☐	SVT
☐	☐	Heart Attack
☐	☐	Pacemaker
☐	☐	Defibrillator
☐	☐	Heart Transplant
☐	☐	High Cholesterol
☐	☐	Wolff-Parkinson – White Syndrome

BLOOD DISORDERS

Yes	No	
☐	☐	Anemia
☐	☐	Sickle Cell Anemia
☐	☐	Hepatitis
☐	☐	Leukemia
☐	☐	HIV
☐	☐	AIDS
☐	☐	Factor 5 Deficiency

NEURO / PSYCHIATRIC

Yes	No	
☐	☐	Stroke
☐	☐	Fainting Spells
☐	☐	Numbness
☐	☐	Myasthenia Gravis
☐	☐	Seizures
☐	☐	Bell's Palsy
☐	☐	Facial Paralysis
☐	☐	Headaches
☐	☐	Migraines
☐	☐	Depression
☐	☐	Anxiety

SKIN CONDITIONS

Yes	No	
☐	☐	Skin Cancer Type & Location: ____________________
☐	☐	Rosacea
☐	☐	Eczema
☐	☐	Psoriasis

RENAL

Yes	No	
☐	☐	Bladder Disease
☐	☐	Kidney Disease
☐	☐	Kidney Stones
☐	☐	Dialysis
☐	☐	Kidney Removal

STOMACH

Yes	No	
☐	☐	Hiatal Hernia
☐	☐	GERD
☐	☐	Diverticulitis
☐	☐	Ulcers

MUSCULOSKELETAL

Yes	No	
☐	☐	Back Pain
☐	☐	Arthritis
☐	☐	Trauma and / or Surgery to Neck or Shoulder – Type: ______________________

RESPIRATORY SYSTEM

Yes	No	
☐	☐	Asthma
☐	☐	Bronchitis
☐	☐	COPD
☐	☐	Emphysema
☐	☐	Sleep Apnea
☐	☐	CPAP
☐	☐	Sarcoidosis

OTHER

______________________________ ______________________________ ______________________________

______________________________ ______________________________ ______________________________

ALLERGIES

☐ Egg ☐ Latex ☐ Betadine ☐ Penicillin ☐ Sulfa

Please list any other allergies: ______________________ ______________________

______________________ ______________________ ______________________

SOCIAL HISTORY

Current Smoker ☐ Yes ☐ No If yes, how long: ____________ How much: ____________

Previous Smoker ☐ Yes ☐ No If yes, how long: ____________ Date quit: ____________

Alcohol ☐ Yes ☐ No If yes, frequency: ____________________

Drug Use ☐ Yes ☐ No If yes, type: ____________________

Occupation: ____

PREVIOUS SURGERIES

______________________ ______________________ ______________________

______________________ ______________________ ______________________

______________________ ______________________ ______________________

Any problems with anesthesia in the past? ☐ Yes ☐ No If yes, what: ______________________________

Any personal history of cancer? ☐ Yes ☐ No If yes, what type: ______________________________

FAMILY HISTORY

☐ Thyroid Disease ☐ Heart Disease ☐ Diabetes ☐ Cancer ☐ Skin Cancer

CURRENT SYMPTOMS OR PROBLEMS YOU ARE HAVING

Yes	No	
☐	☐	Fatigue
☐	☐	Fever
☐	☐	Night Sweats
☐	☐	Increased Sweating
☐	☐	Difficulty Sleeping
☐	☐	Diplopia
☐	☐	Blurred Vision
☐	☐	Eye Pain
☐	☐	Dry Eye
☐	☐	Eyelid Drooping
☐	☐	Visual Impairment
☐	☐	Excessive Tearing
☐	☐	Itching of Eyes
☐	☐	Hearing Loss
☐	☐	Difficulty Swallowing
☐	☐	Ringing in Ear
☐	☐	Sinus Pressure
☐	☐	Runny Nose
☐	☐	Chest Pain
☐	☐	Palpitations

Yes	No	
☐	☐	Rapid Heart Beat
☐	☐	Irregular Heart Beat
☐	☐	Shortness of Breath
☐	☐	Wheezing
☐	☐	Cough
☐	☐	Nausea
☐	☐	Vomiting
☐	☐	Jaundice
☐	☐	Reflux / Heartburn
☐	☐	Blood in Urine
☐	☐	Difficulty with Urination
☐	☐	Increased Urination
☐	☐	Skin Rash
☐	☐	Skin Lesion
☐	☐	Hives or Eczema
☐	☐	Joint Pain
☐	☐	Joint Swelling
☐	☐	Back Pain
☐	☐	Seizure
☐	☐	Dizziness

Yes	No	
☐	☐	Facial Spasms
☐	☐	Weakness
☐	☐	Paralysis
☐	☐	Numbness
☐	☐	Tremor
☐	☐	Vertigo
☐	☐	Headaches
☐	☐	Bruising Tendency
☐	☐	Bleeding Tendency
☐	☐	Anticoagulant Therapy - (Blood Thinners)
☐	☐	Weight Loss
☐	☐	Weight Gain
☐	☐	Heat and/or Cold Intolerance
☐	☐	Increased Thirst
☐	☐	Depression
☐	☐	Anxiety
☐	☐	Mood Swings
☐	☐	Stress

Completed by: ☐ Patient ☐ Family Member (Read and Reviewed with the Patient)

Patient Signature: ________________________________ Date: ____________________

MEDICATION LIST DATE:

Patient Name:	Allergies:

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

CONSULTANTS IN OPHTHALMIC
& FACIAL PLASTIC SURGERY, PC

AUTHORIZATION FOR DISCLOSURE OF TREATMENT

This signature page is designed for you to establish limitations on what information we can share with people other than your insurance company or doctors who coordinate your care. If you have certain family members or caregivers that normally assist you in either your healthcare decisions or financial decisions, you may wish to include them on this form. If you do not authorize anyone on this form, please be aware that we will not be allowed to answer any questions regarding your care, including billing, to anyone but *you* (including your spouse, siblings, adult children and caregivers).

I authorize the person(s) named below to discuss my care in my absence. I understand this authorization is in effect unless I revoke the authorization in writing.

AUTHORIZED INDIVIDUALS:

Name	Relationship	Phone

Specific information to be disclosed (check all that apply):

☐ All Information / No Restrictions ☐ Office Notes

☐ Financial / Billing ☐ Appointments / Scheduling

☐ Diagnostic / Imaging ☐ Other ___________________________________

____
PATIENT NAME PRINTED

____ _________________________
PATIENT SIGNATURE DATE

Forms must be signed and dated each year

Rev. 5-22-19

CONSULTANTS IN OPHTHALMIC
& FACIAL PLASTIC SURGERY, PC

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Dianne M. Schlachter, MD | Robert Beaulieu, MD | Alon Kahana, MD
Lindsay El-Awadi, PA-C | Sara Turner, PA-C

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 Eyelid Surgery***

☐ ***Lower Eyelid Surgery***

☐ ***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)***

CONSULTANTS IN OPHTHALMIC
& FACIAL PLASTIC SURGERY, PC

Cancellation / No Show Policy for Doctor's Appointments and Surgery

1. *Cancellation / No Show policy for Doctor Appointments*

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting needed treatment.

If an appointment is not cancelled at least 24 hours in advance you will be charged a fifty dollars ($50) fee; this will not be covered by your insurance company.

2. *Late Arrival / Scheduled Appointments*

We understand that delays can happen, however we must try to keep the other patients and doctors on time.

If a patient arrives past their scheduled time, we may have to reschedule the appointment.

3. *Cancellation / No Show Policy for Surgery*

Due to the large block time needed for surgery, last minute cancellations can cause problems and added expenses for the office / surgery center.

If surgery is not cancelled at least seven (7) business days in advance, you will be charged a one-hundred-dollar ($100) fee; this will not be covered by your insurance company. If you are having cosmetic surgery, please see the cosmetic surgery cancellation policy.

4. *Account Balances*

We require that patients with outstanding balances pay their account balances to zero ($0) dollars prior to receiving further services by our practice.

Cosmetic Surgery patients must settle their account twenty (30) days prior to their scheduled surgery date, or the surgery will be rescheduled for a later date or cancelled.

Patients who have billing questions or concerns about their bills or would like to discuss payment plan options may call our office at 248-357-5100 and ask to speak to someone in our billing department with whom they can review their account.

I have read and understand the Cancellation / No Show Policy for Consultants in Ophthalmic & Facial Plastic Surgery and agree to its terms.

______________________________	______________________________	________________
Print Patient Name	*Signature of Patient / Guardian*	*Date*

OFFICE USE ONLY Revised: 1-21-19

Patient Account #: ______________________________