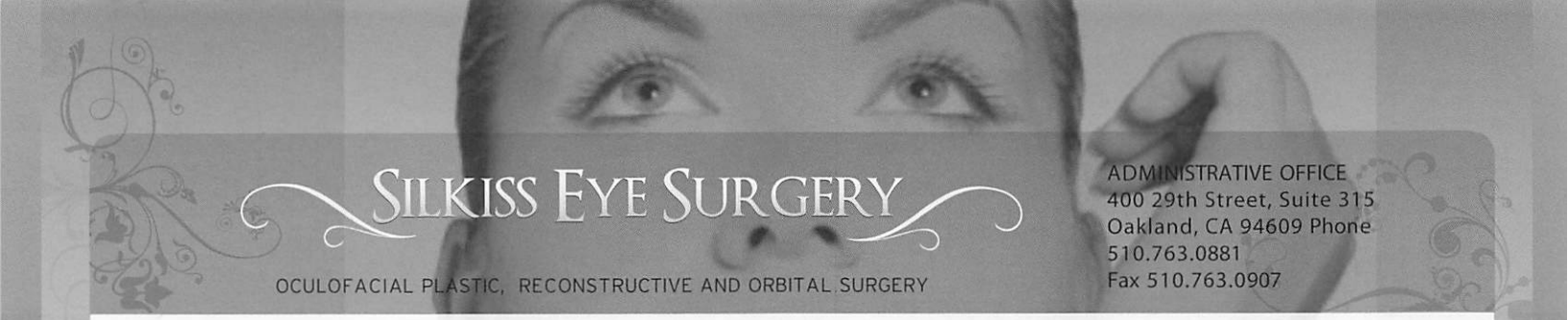


SILKISS EYE SURGERY

OCULOFACIAL PLASTIC, RECONSTRUCTIVE AND ORBITAL SURGERY

ADMINISTRATIVE OFFICE
400 29th Street, Suite 315
Oakland, CA 94609 Phone
510.763.0881
Fax 510.763.0907

Date_____

Name _____ Sex:

Address _____
Street Apt # City State Zip

Birth date _____/_____/_____ Age_____ Soc. Sec #_____/_____/_____

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

E-Mail Address_____

Primary Physician_____
Name City Phone Fax

How did you hear about Silkiss Eye Surgery? _____

Referring Doctor _____
Name City Phone Fax

Emergency Contact: _____
Name Relationship Phone

Preferred Pharmacy _____ Address_____ Phone _____

HEALTHCARE QUESTIONNAIRE

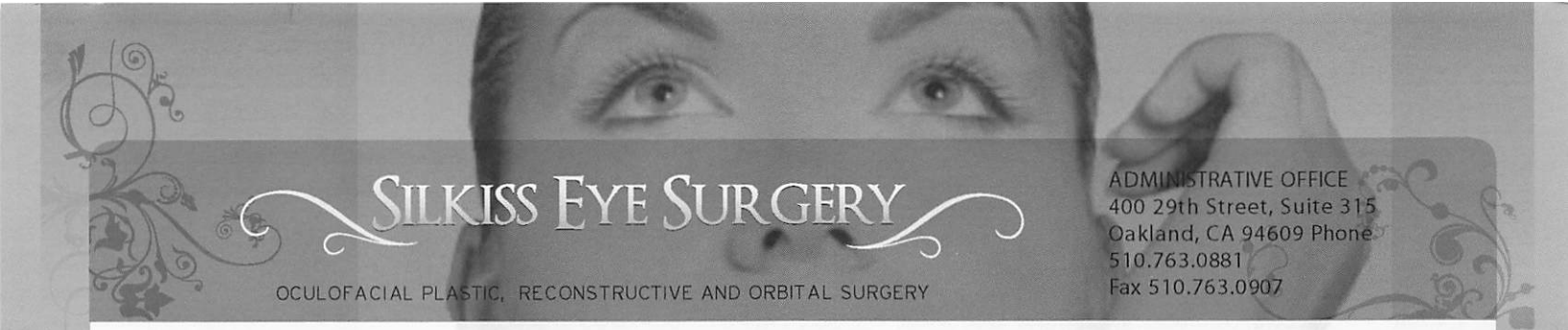
Past Medical History:

Asthma/COPD
Cancer (Please Specify)_____
Depression
Diabetes
Heart Disease (Specify) _____
High Blood Pressure
High Cholesterol
Stroke
Thyroid Disease (Please Specify) _____
Other: _____
_____

Please list your medications:

Name	Dose	Frequency	Route

Allergies: _____



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Date_____

Name _____DOB:_____/_____/_____

Social History

Do you currently smoke or use tobacco products? _____ If yes, have you considered quitting? _____

Do you have a history of smoking/tobacco use? _____ If yes, when did you quit? _____

Do you drink alcohol? _____

If yes: How often do you have a drink containing alcohol? _____

How many standard drinks containing alcohol do you have on a typical day? _____

How often do you have 6 or more drinks on one occasion? _____

Demographics

What is your race?

- Asian or Asian American
- African or African American
- Caucasian or European American
- Native American or Native Alaskan
- Native Hawaiian or other Pacific Islander
- Other: _____

What is your ethnicity?

- Hispanic/Latino
- Non-Hispanic/Latino

Health Screening

1. Did you receive an influenza vaccination this year? _____
   If yes, please list date and provider: _____
2. Have you ever received a pneumococcal vaccination? _____
   If yes, please list date and provider: _____
3. Are you being treated for glaucoma? _____
   If yes, please list provider: _____
4. Do you have diabetes? _____
   If yes, have you received your yearly diabetic eye exam? Date_____Provider_____
   If yes, have you undergone HbA1c testing?_____ Date_____Location_____Result_____
5. Are you being treated for macular degeneration? _____
   If yes, please list provider: _____
6. If you have macular degeneration, are you currently taking eye vitamins or antioxidant supplements? _____
7. If you are over 65, do you worry about falling?_____
8. If you are female, did you receive your mammogram this year? _____

SILKISS EYE SURGERY

RONA Z. SILKISS, MD, FACS
KASRA ELIASIEH, MD

Diplomates, American Board of Ophthalmology

Ophthalmic Plastic, Reconstructive & Orbital Surgery

Cosmetic Eyelid Surgery

TEL 510.763.0881
FAX 510.763.0907
www.eyework.com

400 29th Street
Suite 315
Oakland, CA 94609

1820 San Miguel Drive
Walnut Creek, CA 94596

686 Mowry Avenue
Fremont, CA 94536

100 Tamal Plaza
SUite 120
Corte Madera, CA 94925

15051 Hesperian Boulevard
Suite D
San Leandro, CA 94578

1805 EL Camino Real
Suite 100
Palo Alto, CA 94306

711 Van Ness Avenue
Suite 340
San Francisco, CA 94102

Silkiss Eye Surgery offers Teleheath Medecine appointments. We also send appointment reminders via text messaging. Though there may be personal information in the text messages, no medical information is included.

Please let us know your preference:

- ☐ Yes, I authorize Silkiss Eye Surgery to send me text message reminders
- ☐ No, I do not wish to be contacted via text messaging
- ☐ yes, I authorize Silkiss Eye Surgery to proceed with telemedicine appointments

Please provide mobile phone number of authorizing text messages:

_____

Name: _____

Signature: _____ Date: _____

Silkiss Eye Surgery

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I hereby authorize Silkiss Eye Surgery to release records to my practitioner, hospital, clinic, or other medical or medically related facility, insurance company, or employer, any information regarding my condition. A photocopy of this authorization shall be considered as effective validate as the original.

Patient or guardian signature _____ Date _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

I hereby authorize payment to be made directly to Silkiss Eye Surgery for the medical and, or surgical benefits provided to me. If my insurance company should deny payment for any service received, I will be responsible for payment.

Patient or guardian signature _____ Date _____

MANAGED CARE AGREEMENT

As a member of a managed care plan, I understand that, in most cases, I am responsible for obtaining authorizations from my primary care physician. I also understand signing this agreement; I acknowledge my financial obligation and agree to work with Silkiss Eye Surgery to obtain insurance authorization for each visit.

Patient or guardian signature _____ Date _____

HIP AA ACKNOWLEDGEMENT

I acknowledge that I have read HIP AA Notice of Privacy Practices.

Patient or guardian signature _____ Date _____

CANCELLATION POLICY

A $50.00 cancellation fee may be charged for a no show or late cancellation (within 24hours)

Patient or guardian signature _____ Date _____

SILKISS
EYE
SURGERY

RONA Z. SILKISS, MD, FACS
KASRA ELIASIEH, MD

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Palo Alto, CA 94306

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Suite 340
San Francisco, CA 94102

Cosmetic Consult Questionnaire

Name: _____ Date: _____

How did you hear about us?

_____

What physical areas are you considering for cosmetic treatment?

☐ Face ☐ Eyes/Eyelids ☐ Eyebrow/Forehead
☐ Lips ☐ Cheeks/Midface ☐ Other: _____

What characteristic of the area would you like to improve?

☐ Wrinkles ☐ Volume ☐ Asymmetry
☐ Too Small ☐ Too Prominent ☐ More Youthful
☐ Fat ☐ Color/Pigmentation

Have you had previous cosmetic treatment?

☐ Non-Surgical (Botox, fillers, laser, etc.): _____
☐ Plastic Surgery: _____

What is your ideal time frame for treatment?

☐ Soon ☐ 1-3 months ☐ Other: _____

Is there an upcoming occasion or date you are working with? _____

If yes: _____