



JONATHAN A. HOENIG, MD

OCULOFACIAL PLASTIC & RECONSTRUCTIVE SURGERY

Date _____

PATIENT INFORMATION

First Name _____ Middle Initial _____ Last Name _____

Date of Birth ____ / ____ / ____ Age _____ Sex: M / F Marital Status: M S D W

Soc. Sec. No. ____ - ____ - ____ Employer _____ Occupation _____

Home Street Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____

Work Phone _____ Preferred Contact #: Home Cell Work

Email Address _____ Add to E-Mail List for newsletter & specials? Y / N

Emergency Contact: _____ Relation _____

Contact Address: _____ Phone _____

How did you hear about Dr. Hoenig?

Doctor Friend / Family Internet / Website Name of Referrer: _____

INSURANCE INFORMATION (you may leave blank if you are only having cosmetic procedures)

Subscriber Name _____ Relation to Patient _____

SSN ____ - ____ - ____ Date of Birth ____ / ____ / ____ Phone _____

Primary Insurance _____ Policy # _____ Gp # _____

Secondary Insurance _____ Policy # _____ Gp # _____

I hereby authorize my insurance benefits to be paid directly to Jonathan Hoenig, MD. I agree that I am responsible for copayments, deductibles, and non-covered services. I hereby authorize the release of pertinent medical information to insurance carriers for the purpose of billing.

Patient / Parent / Insured / Guardian

REASON FOR VISIT:

Main Reason: _____

Other Concerns / Areas of Interest: (check all that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> Forehead Lines | <input type="checkbox"/> Thin Lips | <input type="checkbox"/> Skin Fillers/Plumpers |
| <input type="checkbox"/> Frown Lines | <input type="checkbox"/> Jowls | <input type="checkbox"/> Facelift |
| <input type="checkbox"/> Crows Feet | <input type="checkbox"/> Sun Damage | <input type="checkbox"/> Necklift |
| <input type="checkbox"/> Low Eyebrows | <input type="checkbox"/> Brown Spots | <input type="checkbox"/> Cheeklift |
| <input type="checkbox"/> Droopy Eyelids | <input type="checkbox"/> Fine Lines / Wrinkles | <input type="checkbox"/> Eyelid Lift |
| <input type="checkbox"/> Excess Eyelid Skin | <input type="checkbox"/> Skin Cancer | <input type="checkbox"/> Browlift |
| <input type="checkbox"/> Under Eye Bags | <input type="checkbox"/> Sun Protection | <input type="checkbox"/> Lip Augmentation |
| <input type="checkbox"/> Under Eye Darkness | <input type="checkbox"/> Excessive Sweating | <input type="checkbox"/> Lip Lift |
| <input type="checkbox"/> Angry / Tired Look | <input type="checkbox"/> Smile Lines | <input type="checkbox"/> Facial Implants |
| <input type="checkbox"/> Sunken Cheeks | <input type="checkbox"/> BOTOX Cosmetic® | <input type="checkbox"/> Fat Transfer |



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Patient Name _____

Today's Date _____

MEDICAL INFORMATION

Height _____ Weight _____ For you, is this weight Normal _____ Low _____ High _____

Do you now or have you ever smoked? N / Y How much and for how long? _____

Do you drink alcohol? Never _____ Rarely _____ Frequently _____ Daily _____

Do you have ANY ALLERGIES, or reactions to any medicines? No / Yes

If yes, please list allergy and reaction: _____

Please list any PRESCRIPTION medications you take on a regular or occasional basis:

Please list any OVER THE COUNTER MEDICATIONS, HERBS OR VITAMINS you take:

Have you or a family member ever had a reaction to anesthetics? No / Yes _____

When you go to the dentist, do you have a hard time getting or staying numb? No / Yes

Please circle any and all of the following symptoms you have now or have had in the past:

- | | | | |
|--------------------|-----------------|-------------------|----------------------|
| weight loss | double vision | hearing loss | bruise easily |
| fever | dry eyes | ringing in ears | rashes |
| night sweats | eye redness | sore throat | change in moles |
| depression | eye pain | bloody nose | scars |
| heart palpitations | chronic cough | constipation | frequent urination |
| chest pain | bloody sputum | diarrhea | blood in urine |
| heart racing | short of breath | blood in stools | painful urination |
| ankle swelling | wheezing | excessive thirst | lost bladder control |
| headaches | joint pain | bleeding gums | allergic swelling |
| dizziness | muscle pain | unexplained bleed | hives |
| numbness | weak arms/legs | transfusion | other: _____ |

***IF NONE OF THE ABOVE APPLY, PLEASE INITIAL HERE: _____

Please circle any and all of the following conditions you have now or have had in the past:

- | | | |
|---------------------|---------------------|----------------------------|
| heart disease | ulcers or heartburn | HIV+ or AIDS |
| irregular heartbeat | high blood pressure | kidney disease |
| heart murmur | psychiatric care | asthma or emphysema |
| heart attack | thyroid problems | tuberculosis |
| stroke | diabetes | hepatitis or liver disease |
| seizures | arthritis | alcohol or drug addiction |

cancer (please specify type and treatment) _____

other conditions _____



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EYE AND FACIAL HISTORY

Do you have any visual problems?	Y / N	Have you had Bell's Palsy?	Y / N
Do you wear glasses or contacts?	Y / N	Have you had any injury to your eyes?	Y / N
Do you have dry or watery eyes?	Y / N	Have you ever had cataracts?	Y / N
Do you have glaucoma?	Y / N	Have you had laser or other eye surgery?	Y / N

PAST SURGICAL HISTORY (please list all previous surgeries that you have had)

Date _____	Surgery _____	Doctor _____
Date _____	Surgery _____	Doctor _____
Date _____	Surgery _____	Doctor _____
Date _____	Surgery _____	Doctor _____

Please provide any additional information you think we should know: _____

I understand that the above answers are important for my safety during and after surgery or medical care and I, therefore, certify that all of the above answers are true to the best of my knowledge.

Patient Signature

Date

HIPPA ACKNOWLEDGEMENT AND PRIVACY PREFERENCES

You may be contacted by our office to remind you of appointments, healthcare treatment options or other health services that may be of interest to you. To maintain your privacy, please answer:

May we contact you at home?	Y / N	If yes, is it OK to leave msg. at home?	Y / N
May we contact you at work?	Y / N	If yes, is it OK to leave msg. at work?	Y / N
May we contact you on cell phone?	Y / N	If yes, is it OK to leave msg. on cell?	Y / N

Would you like to authorize someone else to schedule, confirm, or change appointments for you?

If so, please provide Name _____ Phone _____

Jonathan Hoenig, MD has provided me with a copy of my rights as a patient under HIPAA (the Health Insurance Portability and Accountability Act). *[Please ask receptionist if you wish to read the full text]*. I have been provided the opportunity to read and understand my rights. I have been provided the opportunity to ask questions regarding my rights & received answers to my satisfaction.

Patient Signature

Date

PHOTOGRAPHIC CONSENT -Dr Hoenig cannot perform any procedures without a signed consent-

In connection with the medical services that I am receiving from Jonathan Hoenig, MD, I consent that photographs may be taken of me. These photos may be used for:

_____ my medical records & education, research or science
 _____ (optional) brochures, before & after photos, website, or other promotion

Patient Signature

Date