MONARCH
EYELID & FACIAL
PLASTIC SURGERY
MEDICAL • SURGICAL • COSMETIC

MANOJ M. THAKKER, MD
719 N. BEERS ST, SUITE 2G
HOLMDEL, NJ 07733
(732) 739-3223

Today's Date_____ **Appointment Date**_____

Last Name_____First Name _____Middle Initial _____

Birthdate _____ Age _____ Title: ☐Mr. ☐Mrs. ☐Dr. ☐Ms. ☐Miss Sex: ☐M ☐F

Address _____City_____State _____Zip_____

Home Phone_____Cell_____Work _____

Email_____ SS#_____

May we leave a detailed voicemail? ☐YES ☐NO Marital Status ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

Occupation _____How did you hear about us? _____

Primary Care Physician: (LAST)_____ (FIRST)_____Phone_____

Address _____City_____State _____Zip_____

Referring Physician: (LAST) _____ (FIRST)____ _____Phone_____

Address _____City_____State _____Zip_____

IN CASE OF EMERGENCY

Name _____Relation _____ Phone _____

PLEASE LIST YOUR PHARMACY (For e-prescribing purposes)

Pharmacy Name: _____Phone _____Address: _____

May we obtain your prescription history directly from your pharmacy? ☐YES ☐NO

Primary Insurance _____ ID number _____

Subscriber Name _____ Subscriber DOB _____ SS#_____

Patient's relationship to subscriber: ☐Self ☐Spouse ☐Child ☐Other

Secondary Insurance _____ ID number_____

Subscriber Name _____ Subscriber DOB _____ SS#_____

Patient's relationship to subscriber: ☐Self ☐Spouse ☐Child ☐Other

Please CHECK all that apply:

PAST MEDICAL HISTORY: ☐ NONE

☐ Anxiety	☐ COPD	☐ HIV / AIDS
☐ Arthritis	☐ Coronary Artery Disease	☐ Hypercholesterolemia
☐ Asthma	☐ Depression	☐ Hypertension
☐ Atrial Fibrillation	☐ Diabetes	☐ Hyperthyroidism (overactive)
☐ BPH	☐ End Stage Renal Disease	☐ Hypothyroidism (underactive)
☐ Bone Marrow Transplant	☐ GERD	☐ Leukemia
☐ Breast Cancer	☐ Hearing Loss	☐ Lung Cancer
☐ Colon Cancer	☐ Hepatitis	☐ Lymphoma
☐ Prostate Cancer	☐ Radiation Treatment	☐ Seizures
☐ Stroke		

Other Important Medical History_____

The information provided in these forms is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand I am responsible for any balance. I also authorize Monarch Eyelid & Facial Plastic Surgery or the insurance company to release any information required to process my claims.

Patient or Parent/ Guardian Signature _____ Date _____

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NAME _____

PAST SURGICAL HISTORY: ☐ NONE

☐ Appendix (Appendectomy)
☐ Bladder (Cystectomy)
☐ Breast: Mastectomy (Right, Left, Bilateral)
☐ Breast: Lumpectomy (Right, Left, Bilateral)
☐ Breast: Breast Biopsy (Right, Left, Bilateral)
☐ Breast: Breast Reduction
☐ Breast: Breast Implants
☐ Colon: Colon Cancer Resection
☐ Colon: Diverticulitis
☐ Colon: Inflammatory Bowel Disease
☐ Gallbladder Removed
☐ Heart: Coronary Artery Bypass (CABO)
☐ Heart: PTCA (Angioplasty)
☐ Heart: Mechanical Valve Replacement
☐ Heart: Biological Valve Replacement
☐ Heart Transplant
☐ Knee Replacement (Right, Left, Bilateral)
☐ Hip Replacement (Right, Left, Bilateral)
☐ Kidney Biopsy
☐ Kidney Removed: (Right, Left)
☐ Kidney Stone Removal
☐ Kidney Transplant
☐ Ovaries Removed: Endometriosis
☐ Ovaries Removed: Cancer
☐ Ovaries Removed: Cyst
☐ Prostate Removed: Cancer
☐ Prostate Biopsy
☐ Prostate: TURP
☐ Skin Biopsy
☐ Skin: Basal Cell Carcinoma Surgery
☐ Skin: Squamous Cell Carcinoma Surgery
☐ Skin: Melanoma Surgery
☐ Spleen Removed
☐ Testicles Removed (Right, Left, Bilateral)
☐ Uterus (Hysterectomy): Fibroids
☐ Uterus (Hysterectomy): Uterine Cancer

Other Important Surgical History _____

REVIEW OF SYSTEMS: ☐ NONE

☐ Problems with bleeding
☐ Fever
☐ Cough
☐ High blood pressure
☐ Shortness of breath
☐ Upset stomach
☐ Gl upset w/ antibiotics
☐ Burning on urination
☐ Thyroid problems
☐ Headaches
☐ Anxiety
☐ Arthritis
☐ Diabetes
☐ Allergies/hay fever
☐ Rapid heart beat
☐ Stroke
☐ Anemia
☐ Weight loss
☐ Eye pain
☐ Tearing
☐ Scalp tenderness
☐ Immunosuppression
☐ Joint aches
☐ Muscle weakness

ALERTS: ☐ NONE

☐ Blood thinners
☐ Artificial joints within past 2 yr
☐ Premedication prior to procedures
☐ Artifical heart valve
☐ Defibrillator
☐ Pacemaker
☐ Allergy to lidocaine
☐ Allergy to adhesive
☐ History of MRSA

ALLERGIES TO MEDICATIONS: (please list drug allergies) ☐ NONE

_____ _____

_____ _____

SOCIAL HISTORY:

IV Drug/Drug Use: ☐ Yes ☐ No

Smoking Use: ☐ Never
☐ Currently Smokes - daily
☐ Currently Smokes - not daily
☐ Has smoked in the past

Alcohol Use: ☐ None
☐ less than 1 drink/day
☐ 1-2 drinks/day
☐ 3 or more drinks /day

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NAME _____

OCULAR HISTORY: ☐ NONE

☐ Allergic Conjunctivitis
☐ Blepharitis
☐ Cataract OD
☐ Cataract OS
☐ Contact Lenses
☐ Corneal Dystrophy, Right
☐ Corneal Dystrophy, Left
☐ Diabetic Retinopathy, Background OD
☐ Diabetic Retinopathy, Background OS
☐ Diabetic Retinopathy, Proliferative OD
☐ Diabetic Retinopathy, Proliferative OS
☐ Dry Eyes
☐ Glasses
☐ Glaucoma OD
☐ Glaucoma OS
☐ Macular Degeneration OD
☐ Macular Degeneration OS
☐ Macular ERM OD
☐ Macular ERM OS
☐ Narrow Angles OD
☐ Narrow Angles OS
☐ Ocular Hypertension OD
☐ Ocular Hypertension OS
☐ Ophthalmic Migraine
☐ Pseudoexfoliation
☐ Retinal Tear OD
☐ Retinal Tear OS
☐ Strabismus
☐ PVD OD
☐ PVD OS
☐ Vitreous Floaters OD
☐ Vitreous Floaters OS

Other Important Ocular History_____

OCULAR SURGERY: ☐ NONE

☐ Blepharoplasty, R / L / Both
☐ Cataract Surgery, R / L / Both
☐ Corneal Transplant, R / L / Both
☐ DSAEK, R / L / Both
☐ Eye Muscle Surgery
☐ Intravitreal Injections
☐ LASIK, R / L / Both
☐ LPI, R / L / Both
☐ LTP, R / L / Both
☐ PRK, R / L / Both
☐ Ptosis Repair, R / L / Both
☐ Punctal Plugs, R / L / Both
☐ Strabismus Surgery
☐ Retinal Laser, R / L / Both
☐ Trabeculectomy, R / L / Both
☐ Tube Shunt, R / L / Both
☐ Yag Capsulotomy, R/ L /Both

Other Important Ocular Surgical History_____

FAMILY HISTORY: ☐ NONE

☐ Blindness
☐ Cancer
☐ Cataracts
☐ Stroke
☐ Diabetes
☐ Glaucoma
☐ Heart Disease
☐ Hypertension
☐ Macular Degeneration
☐ Migraines
☐ Retinal Detachment
☐ Strabismus

Other Important Family History_____

CONSENT FOR PHOTOGRAPHY

I, _____, give permission to Dr. Manoj M. Thakker, his associates, or agents to take photographs of me in the office, during/and or immediately after my procedure, and on subsequent office visits. I also give them permission to photograph any tissue removed during surgery, before or after processing in the pathology laboratory. I understand that the reason for these photographs is to help monitor the course of my treatment. By checking the ACCEPT box below, I am NOT consenting to any type of surgical procedure. ☐ ACCEPT ☐ DECLINE

Furthermore, I grant permission to use these photographs for educational purposes, and/or medical research. I understand that the photographs may be published in professional journals, medical books, or used in educational presentations. In any such event, I will not be identified by name or otherwise personally identified. I expect no compensation for these photographs and waive all rights for any claims for payments and royalties. In addition, I release Monarch Eyelid & Facial Plastic Surgery, its agents, Dr. Thakker, his associates, or his agents from any liability in connection with the use of such photographs. Restrictions of such photographs include the following:

Patient Signature _____ Date _____
Guardian Signature (if necessary) _____ Date _____

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NAME _____

MEDICATIONS/SUPPLEMENTS: (please list all current medications including dosage, frequency, and route)

Route (Oral, IV, etc.)														
Frequency (Daily, Twice Daily, Weekly, etc.)														
Dosage														
Medication Name														

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CO-PAYMENT AND DEDUCTIBLES

Payment is required for all services at the time they are rendered. Co-payments will be collected at the time of service. I understand that in the event that my services are not covered under my insurance, I accept full financial responsibility of those non-covered services. An administrative billing fee of $10 will be applied if co-payments are not paid at the time of service. In the event that your account must be turned over for collections, interest and/or a collection fee at the provider's current rate may be charged on all balances owing that are past due. I further acknowledge that I am responsible for the co-insurance and/or deductible under my health plan's agreement and should my account be sent to a collection agency, I shall be responsible for the collection agency fee or the actual collection cost. Your signature below signifies understanding of this policy.

REFERRAL POLICY

If a referral is required by my health insurance plan, I understand that it is my responsibility to obtain the referral from my primary care provider and assure that it is available at the time of my visit. I further understand that it is my responsibility to keep track of the number of visits I have used, the expiration date, and obtain a new referral as needed. I understand that should I fail to have a valid referral at the time of my visit, I will need to reschedule my appointment.

INSURANCE CARDS

All patients new and returning are required to present their insurance card(s) at every visit. I understand by signing below that I am responsible for notifying the office of any changes to my insurance or contact information.

Patient Signature: _____ Date: _____

CANCELLATION POLICY

Should you be unable to keep your appointment, please contact our office to cancel your appointment at your earliest convenience. Failure to contact our office within 24 hours of the appointment will result in a $25.00 no-show fee. This fee is not reimbursable by your insurance company.

Patient Signature: _____ Date: _____

HIPAA POLICY

Patients 18 years of age or older are protected under the Federal **H**ealth **I**nsurance **P**ortability and **A**ccountability **A**ct. This federal law prohibits any staff member of Monarch Eyelid & Facial Plastic Surgery from discussing appointments, medications, test results, and/or treatment plans with anyone other than the patient. Often, this causes difficulty for some patients who would like family members or care takers to obtain information on their behalf. If you would like to permit someone to discuss your medical condition or obtain results for you, please list their name(s) below. Only individuals names listed will be provided with information. Should you wish to update the names provided, please ask the receptionist at the front desk for a HIPPA form.

Name of Individual (please print) _____
Relationship to Patient _____
Name of Individual (please print) _____
Relationship to Patient _____
Name of Individual (please print) _____
Relationship to Patient _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was given the opportunity to review the Notice of Privacy. I understand a copy of the Privacy Practices is available upon my request (please ask our front desk staff).

Patient Signature: _____ Date: _____

Must be signed by patient 18 years or older. Patients under 18, must be signed by a parent or legal guardian.

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Who is your Primary Care Physician? _____

Month & Year of Last Visit _____

Did you receive the flu vaccine before this past flu season? ☐Yes ☐No

If not, what was the reason?_____

Have you previously received the pneumonia vaccine? ☐Yes ☐No

Do you have a history of melanoma? ☐Yes ☐No

Do you drink 5 or more alcoholic beverages in one day, more than twice a year? ☐Yes ☐No

Do you have an Advance Care Plan? ☐Yes ☐No

If so, what is the name of your Surrogate Decision Maker? _____