PORTLAND
OCULOPLASTICS
SCOT A. SULLIVAN, M.D.
10305 SW Park Way, Suite 203
Portland, OR 97225
Phone: 503.223.8333

Appointment

Day:______________________________

Date:______________________________

Time:______________________________

Dear New Patient: ___________________

We would like to welcome you to Portland Oculoplastics, P.C. This letter is to confirm your appointment with Dr. Sullivan. In this packet, I've enclosed our patient profile, medical history form and notice of privacy practices consent. To help us serve you better, please complete the forms in their entirety and bring them with you on the day of your appointment, along with your current list of medications, surgical history and/or imaging studies related to your condition.

IMPORTANT APPOINTMENT INFORMATION:

- Please bring your insurance card(s) with you so a copy may be made at the time of your appointment.
- We ask that you know in advance which insurance is primary, which is secondary and/or a supplement.
- Please request/obtain a referral from your primary care physician if you're insurance plan requires one (call insurance to find out your plan)
    - Your primary care doctor can fax the referral to our office at (503) 595-8160.
- **If a referral is required but not obtained in advance of your appointment, we will need to reschedule your appointment to allow time for one to be received.**
- Any recent imaging studies related to your condition, including CT and/or MRI scans.
- If you elect to fill out this paperwork in our office please arrive 15 min prior to the scheduled appointment time.

CANCELATION POLICY: We understand that situations may arise which could force you to postpone your upcoming appointment. Please understand that cancellations are often not possible to fill causing vacated slots that could be filled with patients that need to be scheduled sooner.

- We ask that you please provide at least 7 days to postpone or cancel your appointment. If less than 7 days' notice is given for postponement or cancellation, a $50 charge will be billed for appointments and $250 for surgeries.

Due to the nature of our clinic, unforeseen circumstances can appear on a day to day basis. In light of this, your wait time may be longer than originally anticipated, however your time spent with Dr. Sullivan will never be condensed. He will take the time to explain his course of action for your diagnosis and will answer any and all questions you might have regarding the recommended treatment and/or surgery.

If you have any questions, please call our office at (503)223-8333. We want to ensure that your consultation experience is both pleasant and productive.

Sincerely,

Cheyenne Pickering
Patient Care Coordinator

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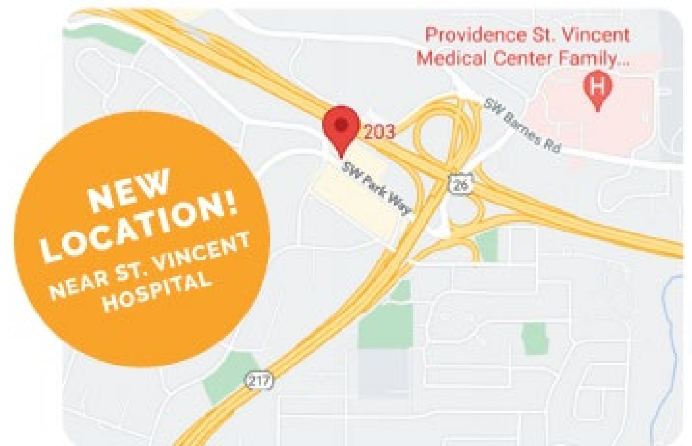
Location & Driving Direction

From US-26 (West)

- Take Park Way/Barnes Rd - Exit #69B
- Continue on Park Way
- Destination on the Right

From US-26 (East)

- Take Park Way/Barnes Rd - Exit #69B
- Left on Baltic Ave
- Right on Park Way
- Destination on the Right



From OR-217 (South)

- Follow signs to US-26 E towards Portland
- Take Wilshire St exit
- Right on Wilshire St (towards DMV)
- Right at stop towards Hwy 26 Tillamook/Astoria
- Left on Park Way
- Destination on the Right

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PATIENT HISTORY RECORD

Date: ____________________

Name: ____ **Date Of Birth:** ___________________________

Address: ____

City: _____________________________________ **State:** _________________ **Zip:** ___________________________

Phone ________________________________ **Email:** ____

Emergency Contact Name: ________________________________ **Phone:** ________________________________

Occupation: ____

Referring Physician: ________________________________ **Phone Number:** ______________________________

Primary Care Physician: ____________________________ **Phone Number:** ______________________________

Primary Care Clinic Name: ____

Reason for Visit: ____

Other Physician: (Please list names and phone numbers of significant practitioners – specialists, cardiologist, neurologist, etc.)

____

____

Pharmacy: (Please list name, location and phone number of local pharmacy you currently use.)

Name: Location: Phone:
____

HISTORY AND INTAKE FORM

Height:______________Weight:______________

Medical History: (please circle all that apply)

Anxiety
Arthritis
Artificial joints
Asthma
Atrial fibrillation
BPH
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Pacemaker
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Valve Replacement
None
Other________________________________

Surgical History: (please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
PTCA
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement within last 2 years
Kidney Biopsy
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP
Skin Biopsy
Basal Cell Cancer Surgery
Squamous Cell Carcinoma Surgery
Melanoma Surgery
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
None
Other________________________________

Ocular History: (Please circle all that apply)

Allergic Conjunctivitis (Left eye, Right eye)

Blepharitis

Cataract (Left eye, Right eye)

Corneal Dystrophy (Left eye, Right eye)

Diabetic Retinopathy, background (Left eye, Right eye)

Dry Eyes

Glaucoma (Left eye, Right eye)

Macular Degeneration (Left eye, Right eye)

Macular ERM (Left eye, Right eye)

Narrow Angles (Left eye, Right eye)

Ocular hypertension (Left eye, Right eye)

Ophthalmic Migraine

Pseudoexfoliation

Retinal Tear (Left eye, Right eye)

Strabismus

PVD (Left eye, Right eye)

Vitreous floaters (Left eye, Right eye)

None

Other________________________________

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____

Ocular Surgery: (Please circle all that apply)

Blepharoplasty (Left eye, Right eye)

Cataract Surgery (Left eye, Right eye)

Corneal Transplant (Left eye, Right eye)

DSAEK (Left eye, Right eye)

Eye Muscle Surgery

Intravitreal injections (Left eye, Right eye)

LASIK (Left eye, Right eye)

LPI (Left eye, Right eye)

LTP (Left eye, Right eye)

PRK (Left eye, Right eye)

Ptosis Repair (Left eye, Right eye)

Punctal Plugs (Left eye, Right eye)

Strabismus Surgery

Retinal Laser (Left eye, Right eye)

Trabeculectomy (Left eye, Right eye)

Tube Shunt (Left eye, Right eye)

Yag Capsulotomy (Left eye, Right eye)

None

Other________________________________

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Medications:
(Please List All Current Medication)

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Allergies:
(Please List All)

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____
____

Social History:
(Please Circle All That Apply)

Cigarette Smoking:
- Never Smoked
- Quit: Former Smoker
- Smoke Less Than Daily
- Smokes Daily

Illicit Drug Use:
- Drug Use
- IV Drug Use

Daily Alcohol Use:
- None
- 1-2 drinks a day
- 3 or more drinks a day

Family History:
(Father, Mother, Grandparents, etc.)

- Blindness
- Cancer
- Cataracts
- CVA
- Diabetes
- Glaucoma
- Heart Disease
- Macular Degeneration
- Migraine
- Retinal Detachment
- Strabismus
- None

Symptoms You Are Currently Experiencing

Poor Vision	Y	N
Eye Pain	Y	N
Tearing	Y	N
Redness	Y	N
Jaw Pain	Y	N
Scalp Tenderness	Y	N
Loss of Vision	Y	N
Fever	Y	N
Chills Weight Loss	Y	N
Stuffy Nose	Y	N
Ear Ache	Y	N
Rapid Heart Rate	Y	N
Cough Congestion	Y	N
Shortness of Breath	Y	N
Upset Stomach	Y	N
Diarrhea	Y	N
Burning Urination	Y	N
Frequent Urination	Y	N
Arthritis	Y	N
Rash	Y	N
Changing Moles	Y	N
Headaches	Y	N
Seizures	Y	N
Anxiety	Y	N
Depression	Y	N
Insomnia	Y	N
Poor Control of Blood Sugar	Y	N

Other Symptoms: ____

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Provider Notice to Patient Regarding Services That Could be Denied Payment by Medicare and/or Other Insurance Companies.

Medicare will only pay for services that it determines to be "reasonable and necessary" under section 1862(a)(1) of the Medicare law. If Medicare determines that a particular service, although it would be otherwise covered, is "not reasonable and necessary" under Medicare program standards, Medicare or other insurance companies could deny payment for that service.

Patient's Acknowledgment and Agreement To Pay/Insurance Authorization and Assignment

I have been notified by my physician/provider that Medicare or other insurance carrier could deny payment for services performed for me. If Medicare or other insurance carrier denies payment, I agree to be personally and fully responsible for payment. I hereby assign benefits to be paid directly to the doctor, and authorize him/her to furnish information regarding my illness to my insurance carrier.

Print Name____**Date**_________________

Signature of Patient ____

Authorization For Use and Release of Medical Photographs

This is a consent document that has been prepared to help inform you concerning permission to take photographs and to use them for a purpose as defined within this document.

It is important that you read this information carefully and completely. After reviewing, please sign the consent. Medical photographs will be taken before, during and after a surgical procedure or treatment.

I hereby authorize Scot A. Sullivan, M.D. and/or their technician to take and/or use pre-operative, intra-operative, and post-operative photographs for professional medical purposes deemed appropriate including but not limited to release to an insurance company if applicable.

Printed Patient Name_______________________________________**Date**___________________

Signature of Patient____

Portland Oculoplastics, PC

10305 SW Park Way, Suite 203
Portland, OR 97225

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I have received a copy of this office's Notice of Privacy Practices. (Available at time of check-in)

____
(Please Print Name)

____
(Signature)

____
(Date)

____
(Or Signature of Legal Representative) Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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