PORTLAND
OCULOPLASTICS

SCOT A. SULLIVAN, M.D.
10305 SW Park Way, Suite 203
Portland, OR 97225
P: 503.223.8333 F: 503.595.8160

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. Please complete the following forms prior to your visit, if unable please arrive 15 Minutes prior.

IMPORTANT INFO:

- Please bring your insurance card(s) with you so a copy may be made at the time of your appointment.
- Please know what insurance is primary, which is secondary and/or a supplement.
- Please bring any recent imaging studies related to your condition, including CT and/or MRI scans.

Prior to Appointment

- Please check if your plan requires a referral from your Primary Care Doctor, if yes please request one, if you don't know contact your Primary Care Office. Referrals can be faxed to our office at (503)595-8160
- **If a referral is required but not obtained prior to your appointment, we will reschedule your appointment until one is obtained.**

APPOINTMENT POLICY: We understand that situations may arise which could force you to postpone your upcoming appointment.

Please note:

- **Any cancelations made within 2 Business Days of your appointment will result in a $50 Charge that is not covered by insurance.**
- **Any surgery cancelations made within 14 Business Days prior to surgery that will result in a $250 Charge that is not covered by insurance.**
- **Arriving more than 15 mins after appointment time we may need to reschedule your appointment.**

Please contact us about our COVID-19 Exposure protocol.

Due to the nature of our clinic, unforeseen circumstances can appear on a day to day basis. Your wait time may vary, however your time spent with Dr. Sullivan will never be condensed.
If you have any questions, please call our office at (503)223-8333.

Sincerely,

Stevie Sheehy

Patient Care Coordinators

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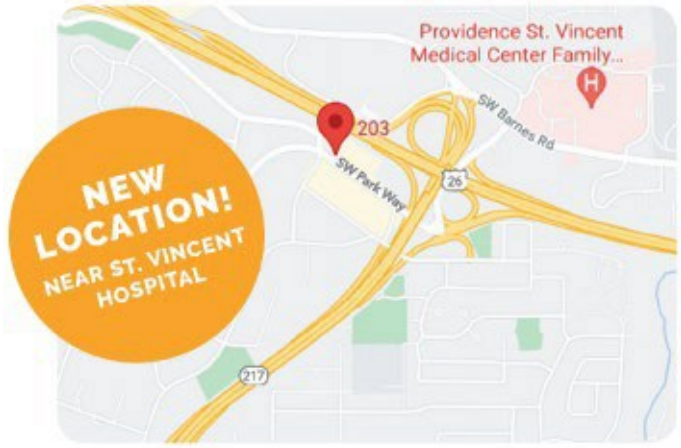
Location & Driving Direction



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:**_____

Occupation:_____

Emergency Contact Name:_____ **Phone:**_____

Relation: _____ **Relationship Status:** ☐ **Married** ☐ **Single** ☐ **Divorced** ☐ **Widowed**

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.)

Name/Specialty:_____ **Phone:**_____

Name/Specialty:_____ **Phone:**_____

Name/Specialty:_____ **Phone:**_____

Name/Specialty:_____ **Phone:**_____

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

Name: Location: Phone:

HISTORY AND INTAKE FORM

Name:_____ **DOB:**_____

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, ___ Right
Lumpectomy Left, ___ Right
Breast Biopsy ___ Left, ___ Right
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 ___ Left, ___ Right
___ Joint Replacement, Hip ___ Left, ___ Right
___ Joint Replacement within last 2 years
___ Kidney Biopsy
___ Kidney Removed ___ Left, ___ Right
___ 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 ___ Left, ___ Right
Hysterectomy: Fibroids
___ Hysterectomy: Uterine Cancer
___ None
Other _____

Name:_____ **DOB:**_____

Ocular History: (Please circle all that apply)

___ Allergic Conjunctivitis

___ Blepharitis

___ Cataract ___Left eye, ___Right eye

___ Corneal Dystrophy ___Left eye, ___Right eye

___ Diabetic Retinopathy, background

___ Dry Eyes ___Left eye, ___Right eye

___ Glaucoma ___Left eye, ___Right eye

___ Macular Degeneratior___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_____

_____

_____

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_____

_____

_____

Name:_____ **DOB:**_____

Medications:

(Please List All Current Medication)

_____

_____

_____

_____

_____

_____

_____

_____

Allergies:

(Please List All)

_____

_____

_____

_____

_____

_____

_____

_____

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

Recreational Drug Use:

Drug:_____
1-2 days a Week
___More Than Half the Week
___ Daily

Family History:

(Father, Mother, Grandparents, etc.)

___ Blindness
___ Cancer
___ CataractsCVA
___ Diabetes
___ Glaucoma
___ Heart Disease
___ Macular Degeneration
___ Migraine
___ Retinal Detachment
___ Strabismus
___ None

COVID-19 History:

(Please Circle All That Apply)

Vaccinated:

___ YES ___ NO ___Decline to Answer

Positive COVID Test in last 20 Days:

___ YES ___ NO ___ Declined to Answer

Symptoms in the Last 14 Days: (Circle All that Apply)

___ Cough ___Shortness of Breath ___ Fever
___ Vomiting ___Muscle/Body Aches ___ Diarrhea
___ Loss of Taste or Smell ___ None

Name:_____ **DOB:**_____

Symptoms You Are <u>Currently</u> Experiencing

	Yes	No
Poor Vision	___	___
Eye Pain	___	___
Tearing	___	___
Redness	___	___
Jaw Pain	___	___
Scalp Tenderness	___	___
Loss of Vision	___	___
Fever	___	___
Chills Weight Loss	___	___
Stuffy Nose	___	___
Ear Ache	___	___
Rapid Heart Rate	___	___
Cough Congestion	___	___
Shortness of Breath	___	___
Upset Stomach	___	___
Diarrhea	___	___
Burning Urination	___	___
Frequent Urination	___	___
Arthritis	___	___
Rash	___	___
Changing Moles	___	___
Headaches	___	___
Seizures	___	___
Anxiety	___	___
Depression	___	___
Insomnia	___	___
Poor Control of Blood Sugar	___	___

Other Symptoms: _____

Portland Oculoplastics, PC

Scot A Sullivan, MD

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
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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)

_____

_____