DAVID S. FELDER, M.D.
2021 East Commercial Boulevard, Suite 306
Ft. Lauderdale, FL 33308

Please fill out this sheet completely. The detailed information is necessary to give you the best possible care. Please print clearly. Although many of the questions may not seem important, due to the wide range of cosmetic and reconstructive surgery, please try to answer all of the sections. Thank you.

NAME: _____ DATE:_____
(Last) (First) (MI)

LOCAL ADDRESS: _____ PHONE: _____

CITY/STATE/ZIP:_____

PERMANENT ADDRESS:_____ PHONE:_____

BIRTHDATE: _____ AGE: _____ MALE FEMALE
(Do Not Omit)

MARITAL STATUS: ☐ MARRIED ☐ SINGLE ☐ WIDOWED

OCCUPATION: _____ NAME OF EMPLOYER:_____

EMAIL ADDRESS:_____

CELL PHONE:_____ BUSINESS PHONE:_____

PROCEDURE(S) INTERESTED IN:_____

REFERRED BY:_____ ADDRESS:_____

IN CASE OF AN EMERGENCY, PLEASE CONTACT:

NAME:_____

HOME PHONE:_____ BUSINESS PHONE:_____

I HEREBY AUTHORIZE DR. FELDER TO RELEASE ANY INFORMATION RENDERED BY HIM WITH MY CONSENTED PERMISSION ONLY.

_____ _____

PATIENT/GUARDIAN SIGNATURE DATE

PHARMACY NAME AND NUMBER_____

MEDICAL HISTORY QUESTIONAIRE

(PLEASE FILL OUT COMPLETELY)

FAMILY PHYSICIAN: _____

PREVIOUS EYE CARE BY:_____

1. REASON TO SEE DR. FELDER FOR A CONSULTATION? _____

_____

2. ARE YOU UNDER A DOCTOR'S CARE FOR ANY ILLNESS? (i.e., Diabetes, Cancer, Hypertension, etc.)_____

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3. LIST ALL MEDICATIONS, INCLUDING ASPIRIN OR ANY VITAMINS/HERBS: _____

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4. LIST ALL THE PERTINENT SURGERY OR HOSPITALIZATION YOU HAVE HAD: _____

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5. HAVE YOU EVER BEEN DIAGNOSISED WITH AIDS OR HIV?_____

6. LIST ALL ALLERGIES TO ANY MEDICATIONS YOU HAVE: _____

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7. HAVE YOU USED ACCUTANE FOR ACNE IN THE LAST TWO YEARS? _____

8. HAVE YOU EVER HAD ANY CHEMICAL PEELS? IF SO, WHAT TYPE AND WHEN: _____

Patient Consent Form

(Please Read and Sign)

I, the undersigned, hereby consent to the following:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures/tests
- Taking and utilization of cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees.

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. **The consent will remain in full force until revoked in writing.**

I, the undersigned, acknowledge that Dr. David S. Felder, Cosmetic Eyelid and Laser Center of South Florida, may use my information for the purposes of treatment, payment, and healthcare operations.

Treatment includes but is not limited to: the administration and performance of all treatments, the administration of any needed anesthetics, the use of prescribed medication; the performance of such procedures as may be deemed necessary or advisable in the treatment of this patient, such as diagnostic procedures, the taking and utilization of cultures and of other medically accepted laboratory tests, all of which the judgment of the attending physician or their assigned designees, may be considered medically necessary or advisable.

Payment includes but is not limited to: the authorization of payment directly to **Dr. David S. Felder and Cosmetic Eyelid and Laser Center of South Florida**. I hereby authorize the release of my medical records to authorized persons to whom disclosure is necessary to establish or collect a fee for the services provided, such as billing and collection services, insurance payers, auto accident insurers, or for work related injury, to my employer or designee understand that I am financially responsible for charges not covered by this authorization. I acknowledge that patient records may be stored electronically and made available through computer networks.

Healthcare Operations include but are not limited to: release of my medical information to any of my physicians and their offices or insurance companies participating in my care or treatment.

I fully understand that this given in advance of any specific diagnosis or treatment. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing. This consent specifically includes the release of medical information concerning drug-related conditions, alcoholism, psychological conditions, and/or infectious diseases including but not limited to blood-borne diseases.

A photocopy of this consent shall be considered as valid as the original.

I acknowledge that I have reviewed this facility's Notice of Privacy Practices, and I understand that I may request a copy of this document. I understand that if I have questions or complaints that I should contact the Office Manager. I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

Patient *(or Responsible Party)* Signature Date