KEVIN I. PERMAN, MD P.C.
THE CENTER FOR EYELID AND FACIAL PLASTIC SURGERY, LLC.

PATIENT REGISTRATION

LAST NAME:_____ FIRST NAME:_____ MI:_____

ADDRESS: _____

City_____ State_____Zip Code_____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

EMAIL ADDRESS: _____

STATUS: *Married* *Single* *Divorced* *Widowed* GENDER: *Male* *Female*

EMPLOYER: _____ JOB TITLE: _____

WORK ADDRESS: _____

REFERRING PHYSICIAN: _____ PHONE: _____

PRIMARY CARE PHYSICIAN: _____ PHONE: _____

OTHER PHYSICIAN: _____ PHONE: _____

EMERGENCY CONTACT NAME: _____ RELATIONSHIP: _____

ADDRESS: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: _____

ADDRESS: _____ PHONE: _____

SUBSCRIBER'S NAME: _____ RELATIONSHIP: *Self* *Spouse* *Parent*

SUBSCRIBER'S DATE OF BIRTH: _____ SUBSCRIBER'S SS#: _____

ID NUMBER: _____ GROUP NUMBER; _____

SECONDARY INSURANCE COMPANY: _____

ADDRESS: _____ PHONE: _____

SUBSCRIBER'S NAME: _____ RELATIONSHIP: *Self* *Spouse* *Parent*

SUBSCRIBER'S DATE OF BIRTH: _____ SUBSCRIBER'S SS#: _____

ID NUMBER: _____ GROUP NUMBER; _____

I request that payment of authorized benefits (including Medicare) be made on my behalf to Kevin I. Perman, M.D., PC . or The Center for Eyelid and Facial Plastic Surgery, LLC. for any services furnished to me by physician or supplier. I authorize the release of any medical information necessary to process claims. I permit a copy of this authorization to be used in place of the original. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

I certify that the information I have reported with regard to my insurance coverage is correct. Either my insurance company or I may revoke this authorization at any time in writing. I understand that I am financially responsible for all charges, whether or not paid by my insurance. I further understand that I will be responsible for any additional charges that are incurred on my behalf (including bank charges, attorney fees and collection fees.)
I hearby authorize said assignee to release all information necessary to secure this payment.

SIGNATURE: _____ **DATE:** _____

For office use:

All of the information above is correct / No changes

Signature: _____ Date: _____	Signature: _____ Date: _____

KEVIN I. PERMAN, MD P.C.
HEALTH INFORMATION & HISTORY

NAME OF PATIENT: _____ **Date of Birth:** _____

Primary Care Physician: _____ **Height:** _____ **Weight:** _____

Please circle "Yes" or "No" to indicate if you have had any of the following:

Anemia	Yes	No	Arthritis	Yes	No
Asthma	Yes	No	Diabetes	Yes	No
Emphysema/ COPD	Yes	No	Hypoglycemia	Yes	No
Bronchitis/ Chronic Cough	Yes	No	Thyroid Condition	Yes	No
Sleep Apnea	Yes	No	Cancer	Yes	No
If yes, do you have CPAP?	Yes	No	Lupus	Yes	No
Tuberculosis	Yes	No	Lazy Eye	Yes	No
Hepatitis (Type ____)	Yes	No	Poor Color Vision	Yes	No
Kidney Disease	Yes	No	Retinal Disease	Yes	No
High Blood Pressure	Yes	No	Blindness	Yes	No
Low Blood Pressure	Yes	No	Glaucoma	Yes	No
Heart Attack	Yes	No	Epilepsy/Seizures	Yes	No
Heart Failure	Yes	No	Headaches/Migraines	Yes	No
Irregular Heartbeat	Yes	No	AIDS/HIV	Yes	No
Heart Murmur	Yes	No	STIs	Yes	No
Pacemaker	Yes	No	Shingles/Herpes	Yes	No
If yes, do you have an ICD?	Yes	No	Are you pregnant?	Yes	No
Angina	Yes	No	Tobacco Use?	Yes	No
Stroke	Yes	No	Alcohol Use?	Yes	No
Bleeding Tendencies	Yes	No	Recreational Drugs?	Yes	No
Blood Clots/ Embolism	Yes	No	Wear contact lenses?	Yes	No

Current vaccinations (with dates): Flu: _____ **Shingles:** _____ **Pneumonia:** _____ **Covid-19**_____

Other MEDICAL CONDITIONS, DISABILITIES, or RISK of FALLING? ***If yes, please list:***

_____

MEDICATIONS: *Please list any medications you are currently taking, including herbs, vitamins, and eye drops.*

_____

_____

Pharmacy Name:_____ Pharmacy Phone Number: _____

ALLERGIES: _____

PRIOR SURGERIES: _____

_____

SIGNATURE: _____ **DATE:** _____

Rev: April 2021

Kevin I. Perman, M.D

THE CENTER FOR
EYELID &
FACIAL PLASTIC
SURGERY, L.L.C.

www.eyelidsandface.com

Office Locations:

Bethesda
6420 Rockledge Drive
Suite 4300
Bethesda, MD 20817
301-571-0000
Fax: 301-571-0853

Fairfax
8503 Arlington Blvd.
Suite 130
Fairfax, VA 22031
703-849-8185

Gainesville
7051 Heathcote Village Way
Suite 155
Gainesville, VA 20155
703-341-9800

Washington
900 17th ST., NW
Suite 400
Washington, DC 20006
202-615-5525

Limited to:
* Aesthetic Eyelid and Facial Plastic Surgery
* Diseases and Surgery of the Eyelids, Orbit and Lacrimal Apparatus
* Facial Rejuvenation and Face Lift Surgery
* Botox Injections, Facial Fillers
* Facial Laser and Endoscopic Surgery
* Thyroid Ophthalmopathy

Please address all correspondence to the Bethesda office

Thank you for choosing this practice as your health care provider.

PATIENT RIGHTS AND RESPONSIBILITIES

Kevin I. Perman, MD is committed to ensuring the following patient rights:

Your right to safe, confidential, professional and considerate care.

Your right to privacy regarding your personal care.

Your right to refuse part or all of the treatment suggested to you.

Your right to be informed prior to a procedure about any treatment that would be performed and the risks and dangers of that treatment.

Your right to voice grievances and recommend changes in polices to my staff.

As a patient you are responsible for:

Providing an accurate and complete history about your health status, including all medications and supplements you are currently taking.

Providing a copy of your health insurance card(s).

Providing a copy of your referral at the time of your visit if required by your insurance carrier.

Following the treatment plan recommended by Dr. Perman.

OUR FINANCIAL POLICY

Please understand that payment of your bill is considered part of your treatment. This practice is committed to providing the best treatment for each patient. Our charges are usual and customary for this area.

All patients must complete the information and insurance forms before seeing the doctor.

All co-payments, deductibles and required referrals are due at the time of treatment.

This practice does not accept assignment of indemnity insurance.

Any services provided which may be deemed *non-covered services* and/or not considered *reasonable and necessary* by your insurance carrier will be the patient's responsibility.

Cash, personal checks, VISA and MasterCard are accepted.

I have read the Patient Rights and Responsibilities and the Financial Policy of this practice. I understand and agree to these terms.

_____ _____

Signature of Patient or Responsible Party Date