OCULOFACIAL PLASTIC SURGERY
P. EMMETT HURLEY MD,MS
5800 MAIN ST WILLIAMSVILLE, NY 14221
PH: (716) 932-7670 FAX: (716) 276-9711
PLASTICEYEDR.COM

Your Name & Information: (circle one) Dr. Mr. Mrs. Miss

☐ Male ☐ Female

Last _____ First _____ MI _____

Street _____

City _____ State _____ Zip _____

Email _____*(providing your email will give you access to your online health records, secure messaging with the doctor, and appointment reminders)*

Home Phone _____ Mobile Phone _____Work Phone _____

Preferred method of contact: ☐ Home ☐ Work ☐ Mobile ☐ Email ☐ Mail

Social Security #_____ Date of Birth_____ Marital Status S M W D

Ethnicity: ☐ Hispanic or Latino ☐ NOT Hispanic or Latino ☐ Unknown

Preferred Language: ☐ English ☐ Other _____

Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American
☐ Native Hawaiian ☐ White ☐ Other _____

Emergency Contact Name: _____ Phone _____

Relationship _____

Family Doctor's Name: _____

Address _____ Phone _____

Pharmacy Name: _____

Address _____ Phone _____

Employer's Name: _____ Phone _____

Address _____ Occupation _____

How did you hear about us? _____

Insurance _____**Subscriber**_____

Relation to Insured:☐ Self ☐Spouse ☐ Child ☐Other **DOB of Subscriber** _____

Print Your Name _____ **Date of Birth** _____

Insurance Authorization:

I the undersigned give my authorization to treat and assign directly to Oculofacial Plastic Surgery of WNY all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am ultimately financially responsible for all approved and covered charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions

_____ _____
Patient Signature Date

Financial Policy Acknowledgement:

I acknowledge I am aware that if I fail to appear for my scheduled appointment I will be charged a fee of $50.00 unless I cancel the appointment with at least 24 hours notice. I understand that payment of non-covered services, co-pays and deductibles are expected at the time of service.

_____ _____
Patient Signature Date

HIPAA Acknowledgement:

I acknowledge receipts of the Practice's Notice of Privacy Practices. I authorize the Practice to use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me and conducting healthcare operations.

I permit a copy of this authorization to be used in place of the original.

_____ _____
Patient Signature Date

Medication History Consent:

I understand that my medication history may be obtained utilizing an electronic information exchange and that this protected health information may provide valuable information for my healthcare provider.

I hereby authorize Oculofacial Plastic Surgery of WNY to access my medication history without limitation or exclusion as is required and/or reasonably advisable to disclose, process, retrieve, transmit, and view for the purpose of the transmission of an electronic prescription issued by a provider authorized by law to prescribe, as necessary for my care and treatment.

_____ _____
Patient Signature Date