Selena Fu, M.D.
13300 Metcalf Ave, Overland Park, KS 66213
913-387-1104

Client Information: (Please use full legal name)
Last name: _____ First name: _____ MI: _____
Address: _____
City: _____ State: _____ Zip: _____
Cell phone: _____ Home/Work phone: _____
Date of birth: _____ Age: ____ Email address: _____
Social Security #: _____ Sex: M or F Marital status: _____
Employer: _____ Occupation: _____
Emergency Contact: _____ Contact phone: _____
Relationship: _____

Guarantor Information: (List person responsible if patient is underage)
____Self (skip this section) ____Parent ____Spouse ____Other
Last name: _____ First name: _____ MI: _____
Address: _____
City: _____ State: _____ Zip: _____
Cell phone: _____ Home/ Work phone: _____
Date of birth: _____ Email address: _____
Social Security #: _____ Sex: M or F Marital status: _____
Employer: _____ Occupation: _____

Billing Information:
Primary insurance: _____ ID #: _____
Policy holder name: _____ Policy holder DOB: _____
Secondary Insurance: _____ ID #: _____
Policy holder name: _____ Policy holder DOB: _____

I have been informed of the Privacy Practices and Financial Responsibility policy provided by Dr. Fu.

_____ _____
Signature of Patient or Patient representative Date

Health Insurance Portability and Accountability Act (HIPAA) Waiver
As Dr. Fu is bound by the rules of the Health Insurance Portability and Accountability Act (HIPAA), we are unable to provide any information to any person other than you without your consent. This includes information about your account, appointment times, prescriptions, or any information contained in your records with us. Please list any persons or agencies that we have your permission to release your information to. This information can be amended by you as needed.

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

Name _____ DOB _____

Whom may we thank for telling you about our practice? Please circle. Friend Family Website Facebook Health fair Insurance Doctor Optometrist Ophthalmologist Dermatologist

Friend/ Family _____ Website_____
MD/ DO_____ Ophthalmologist / Optometrist _____
Primary Care Doctor Name _____ Phone _____
Doctor Address_____

Health History (Y for yes, Blank for No)

_____Heart _____ _____Ear/ Nose/ Throat _____
_____Lung__ _____ _____Neuro Stroke Seizure _____
_____Tuberculosis_____ _____Extensive illness or injury_____
_____Diabetes_____ _____Temporal arteritis_____
_____Migraines_____ _____Kidney_____
_____Psychiatric disorder_____ _____Autoimmune _____
_____Anxiety_____ _____HIV_____
_____Thyroid_____ _____Liver _____
_____GI _____ _____Arthritis _____
_____Hypertension_____ _____Cancer_____
_____Skin _____ _____Other_____

Eye History (Include yr or age)

___Cataract ___Glaucoma ___Corneal disease ___Retinal disease ___Crossed eye
___Lazy eye ___Iritis / Uveitis ___Eye muscle surgery ___Eye lid surgery _____
___Eye surgery _____ Other_____

Surgical History please indicate type and year

_____
_____

Medication including OTC and eye drops

_____
_____
_____

Allergy to medication

_____

Aesthetic History

Please circle concerns below or write it here _____
Droopy brow Droopy eyelids Eyebags Facial wrinkles Frown lines Forehead lines Crow's feet Smile lines Facial drooping Jowling Marionette lines Square jaw Round face Hollow temple "Orange peel" chin Recessed chin Double chin Thin lips Lip lines Down-turned mouth Neck lines Ear lobe sagging Facial redness Brown / age spots Acne White / Black heads Mole / rashes Blotchy skin Length / fullness of Eyelashes Thinning Hands Sweaty hands / armpits Scars where _____

___Botox type injection _____Date of last injection Injection Location / dose_____
___Filler injection _____Date of last injection Injection Location / syringes _____
___Chemical peel _____Date of last peel Type of peel_____
___Laser treatment _____Date of laser tx Type and location _____

Social History

Do you or did you smoke? Y/ N Do you drink alcohol? Y/N Do you use recreational drugs? Y/N
How much? _____

Family History

___Glaucoma ___Macular degeneration ___Retinitis Pigmentosa ___Retinal detachment ___Corneal disease
___Heart disease ___Stroke ___Diabetes ___Skin cancer
Other_____