NAME: _____ REFERRING DOCTOR: _____

DATE: _____ /_____ /_____ MEDICAL DOCTOR: _____

DOB: _____ /_____ /_____ PHARMACY NAME: _____

DRUG ALLERGIES: _____ PHARMACY LOCATION/PHONE #: _____

MEDICATIONS & DOSES:

1. _____ 5. _____ 9. _____
2. _____ 6. _____ 10. _____
3. _____ 7. _____ 11. _____
4. _____ 8. _____ 12. _____

MEDICAL HISTORY	PLEASE CHECK (√) YES OR NO	
STROKE OR PARALYSIS	_____ YES	_____ NO
ARTHRITIS OR RHEUMATOLOGIC DISEASE	_____ YES	_____ NO
ASTHMA / EMPHYSEMA	_____ YES	_____ NO
BRADYCARDIA (SLOW PULSE)	_____ YES	_____ NO
DIABETES: ____ TYPE 1 OR ___ TYPE 2	_____ YES	_____ NO
CANCER: SITE _____	_____ YES	_____ NO
CONGESTIVE HEART FAILURE	_____ YES	_____ NO
KIDNEY STONES	_____ YES	_____ NO
HYPERTENSION (HIGH BLOOD PRESSURE)	_____ YES	_____ NO
AIDS/HIV	_____ YES	_____ NO
OTHER: _____	_____ YES	_____ NO

SOCIAL HISTORY

ALCOHOL CONSUMPTION: _____	_____ YES	_____ NO
SMOKER: HOW MUCH: _____	_____ YES	_____ NO
FORMER SMOKER: QUIT: _____	_____ YES	_____ NO

FAMILY HISTORY	MOTHER	FATHER
RETINAL DETACHMENT	____ YES ____ NO	____ YES ____ NO
GLAUCOMA	____ YES ____ NO	____ YES ____ NO
DIABETES	____ YES ____ NO	____ YES ____ NO
RETINITIS PIGMENTOSA	____ YES ____ NO	____ YES ____ NO
OTHER: _____	____ YES ____ NO	____ YES ____ NO

REVIEW OF SYMPTOMS (CIRCLE ALL THAT CURRENTLY APPLIES TO YOU) **EXPLAIN**

FEVER – CHILLS – WEIGHT CHANGE – SWEATS- HEADACHES
SCALP TENDERNESS – SORE THROAT - HEARING PROBLEMS – EAR PAIN
CHEST PAIN – PALPITATIONS – SLOW PULSE - FAINTING
SHORTNESS OF BREATH – COUGH - SLEEP APNEA
NAUSEA – VOMITING – DIARRHEA - ABDOMINAL PAIN
PAIN IN URINATION – BLOOD IN URINE – DISCHARGE
DIGESTIVE PROBLEMS – INTESTINE PROBLEMS
MUSCLE – JOINT PAIN - WEAKNESS – NUMBNESS - SEIZURES
SKIN RASHES – SORES – RECURRENT INFECTIONS
DEPRESSION – ANXIETY – AGITATION
EXCESSIVE THIRST – URINATION – HORMONE PROBLEMS
EASY BRUISING -BLEEDING – ANEMIA- SWOLLEN GLANDS – IMMUNE SYSTEM PROBLEMS
ALLERGIES (I.E. POLLEN, SHELLFISH, ETC.):

LIST SURGERIES: _____

_____

PATIENT'S SIGNATURE: _____

MIDATLANTIC OPHTHALMOLOGY

PATIENT INFORMATION **DATE: _____ /_____ /_____**

Last Name: _____ First Name: _____ MI: _____

Birthday: ____ /____ /____ Sex: M / F Height: _____ Weight: _____ Marital Status: S, M, W, D

Ethnicity: _____ Race: _____ Preferred Language: _____

Social Security Number: _____ E-Mail Address: _____

Home Phone Number: _____ Cell Phone Number: _____

Home Address: _____City: _____ State: _____ Zip: _____

Occupation: _____ Employer Name: _____ Work Number: _____

Employer's Address: _____ City: _____ State: _____ Zip: _____

Spouse or Parent's Name: _____ Address: _____ Zip: _____

Spouse or Parent's Employer: _____ Occupation: _____ Work Ph #: _____

Employer's Address: _____ City: _____ State: _____ Zip: _____

Have you or anyone in your family been here before? ___ Yes ___ No If yes, which doctor? _____

Were you referred to this office? ___ Yes ___ No If yes, how were you referred? _____

INSURANCE INFORMATION:

Primary Insurance: _____ Address: _____

Member ID #: _____ Group #: _____

Subscriber's Name: _____ DOB: ____ /____ /____

Secondary Insurance: _____ Address: _____

Member ID #: _____ Group #: _____

Subscriber's Name: _____ DOB: ____ /____ /____

IF PATIENT IS NOT RESPONSIBLE FOR BILL, PLEASE FILL IN THE FOLLOWING:

Guarantor: _____ Home Phone #: _____ Work Phone #: _____

Address: _____ City: _____ State: ____ Zip: _____

Birth Date: ___ /___ /___ Social Security #: _____ Sex: M / F Employer: _____

I understand that Medicare and most insurance companies DO NOT PAY FOR REFRACTION, when needed to assess the best corrected visual acuity or to prescribe glasses. Medicare and many insurance companies do not cover routine eye examinations. Medicare will not pay for routine eye exams.

SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT

1. **RELEASE OF INFORMATION: MidAtlantic Eye Center may disclose all or any part of my medical record and/or financial ledger, including information on alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to MidAtlantic Eye Center for reimbursement of services rendered, and (2) any health care provider for continued care.**

2. **NON-COVERED SERVICES: I understand that MidAtlantic Eye Center's contracts with health care service plans (i.e., HMOs, PPOs) relate only to items and services which are "covered" by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items and services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, refraction, services not specified as being covered in the patient's contract with a health service plan or in the benefit summary the health care service plan furnishes to the patient and treatments, or tests not authorized by the health care service plan. The undersigned agrees to cooperate with MidAtlantic Eye Center to obtain necessary health care service plan authorizations.**

3. **FINANCIAL AGREEMENT: I agree that in return for the services provided to the patient by MidAtlantic Eye Center, I will pay my account at the time service is rendered or will make arrangements satisfactory to MidAtlantic Eye Center for payment. I agree to pay a monthly 1.5% interest charge on any overdue balance. If an account is sent to an attorney for collection, I agree to pay any collection expenses and reasonable attorney's fee as established by the court and not by a jury in any court action. Any benefit of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is assigned to MidAtlantic Eye Center. If co-payment and/or deductibles are designated by my insurance company or health plans, I agree to pay them to MidAtlantic Eye Center. <u>I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED IN THE EVENT THAT MY INSURANCE DENIES PAYMENT.</u>**

4. **MEDICARE: I request that payment of unauthorized Medicare benefits be made on my behalf to MidAtlantic Eye Center for services furnished to me by MidAtlantic Eye Center. I authorize any holder of medical information about me to release to the Center of Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests the payment be made and authorize the release of medical information necessary to pay the claim. If other insurance is indicated on the claim form, any signature authorizes releasing the information to the insurer or agency shown. MidAtlantic Eye Center accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, co-insurance, and uncovered service. Co-insurance and deductibles are based upon the charge determination of the Medicare carrier. <u>I AM RESPONSIBLE FOR THE 20% MEDICARE COPAY, ANY DEDUCTIBLES, AND NON-COVERED SERVICES.</u>**

5. **The doctors and staff of MidAtlantic Eye Center have my permission to discuss my personal health information with the following people: _____ _____ _____**
   Name Relationship Phone Number

6. **By my signature I acknowledge that the privacy policies and patient rights of MidAtlantic Eye Center have been made available to me.**

   HOWEVER, IT IS UNDERSTOOD THAT THE UNDERSIGNED AND/OR THE PATIENT ARE PRIMARILY RESPONSIBLE FOR THE PAYMENT OF MY BILL.

PRINT PATIENT'S NAME: _____

PATIENT SIGNATURE/AUTHORIZED PARTY: _____ DATE: ____ /____ /____