MEDICAL-SURGICAL EYE CARE, P.A.

DATE_____

PATIENT'S NAME:_____

ADDRESS:_____SS#_____

CITY/STATE/ZIP:_____DATE OF BIRTH:_____

MARTIAL STATUS: M S D W SEX: M F AGE:_____

HOME PHONE: ( )_____CELLPHONE: ( )_____

IF CHILD; PARENT OR GUARDIAN NAME:_____

EMERGENCY CONTACT:_____PHONE:_____

RELATIONSHIP TO PATIENT:_____ADDRESS: _____

PATIENT EMPLOYER INFORMATION

EMPLOYER NAME:_____PHONE_____

EMPLOYER ADDRESS:_____

SPOUSE INFORMATION

SPOUSE NAME:_____SS#_____

SPOUSE EMPLOYER:_____PHONE:_____

SPOUSE EMPLOYER ADDRESS:_____

INSURANCE

PRIMARY INSURANCE COMPANY:_____

I.D.#_____GROUP#_____

INSURED PERSON IF NOT PATIENT:_____

DATE OF BIRTH:_____SS#_____

SECONDARY INSURANCE COMPANY:_____

I.D.4_____GROUP#_____

INSURED PERSON IF NOT PATIENT:_____

DATE OF BIRTH:_____SS#_____

HOW DID YOU HEAR ABOUT OUR OFFICE?_____

REFERRING DOCTOR: _____

PRIMARY CARE PHYSICAN:_____

PCP ADDRESS:_____PHONE:_____

LIFETIME AUTHORIZATION & CONSENT FORM

I REQUEST THAT ALL PAYMENTS OF AUTHORIZED INSURANCE BENEFITS ON MY BEHALF BE PAID TO MEDICAL SURGICAL EYE CARE, P.A. FOR ALL SERVICES RENDERED TO ME. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME BE RELEASED TO THE INSURANCE COMPANY. I UNDERSTAND THAT SERVICES FOR WHICH I AM TREATED MAY OR MAY NOT BE COVERED BY MY INSURANCE. I AM AWARE THAT I CAN BE BILLED AND I AM RESPONSIBLE FOR ANY NON-COVERED CHARGES ON MY (OR MY DEPENDENTS) ACCOUNTS WITH MEDICAL SURGICAL EYE CARE, P.A.

PATIENTS SIGNATURE:_____DATE:_____

RELEASE OF INFORMATION

I GIVE MY PERMISSION TO MEDICAL SURGICAL EYE CARE, P.A. AND STAFF, TO RELEASE ALL INFORMATION PERTAINING TO MYSELF TO MY INSURANCE CARRIER. THIS INCLUDES ALL LAB, VISITS AND PROCEDURES.

PATIENT.

SIGNATURE:_____DATE:_____

PATIENT RESPONSIBILITY FOR PAYMENT

I UNDERSTAND THAT I MAY BE FINANCIALLY RESPONSIBLE FOR ALL OR A PORTION OF SERVICES RENDERED TO ME TODAY. IN ACCORDANCE WITH HEALTH CARE FINANCE ADMINISTRATION OUR OFFICE IS EXPECTED TO REPORT APPROPRIATE CODING AND DIAGNOSIS INFORMATION THAT REFLECT THE TYPE OF VISIT YOU HAD IN OUR OFFICE. YOUR INSURANCE COMPANY MAY PAY FOR ALL OR ONLY A PORTION OF THE SERVICES. THE CHARGES MAY BE APPLIED TO YOUR DEDUCTIBLE, OR SOME SERVICE MAY BE CONSIDERED "NON-COVERED" BENEFITS SUCH AS PREVENTIVE MEDICINE VISITS.

THANK YOU FOR UNDERSTANDING OUR OFFICE OBLIGATION TO THE FEDERAL GOVERNMENT REGULATIONS. IT IS OUR GOAL TO PROVIDE QUALITY HEALTH CARE AT THE LOWEST POSSIBLE COST.

PATIENT SIGNATURE: _____DATE:_____

WE WOULD LIKE TO THANK YOU FOR CHOOSING MEDICAL SURGICAL EYE CARE, P.A. FOR YOUR HEALTH CARE NEEDS. WHETHER YOU COME TO US BY REFERRAL, FROM ANOTHER PHYSICIAN, BY DIRECTION OF YOUR INSURANCE COMPANY, OR LIKE MANY OTHERS, BY THE REFERRAL OF A FRIEND OR RELATIVE, WE WILL STRIVE TO PROVIDE YOU WITH THE MOST COMPLETE AND UP-TO-DATE CARE POSSIBLE.

Medical - Surgical Eye Care, P.A.

HEALTH HISTORY

Name: _____

Date: _____

Birthdate: _____ Chart # _____

1. Review of Systems

EYES

Loss of Vision	y	N	Blurred Vision	y	N
Distorted Vision (halos)	y	N	Loss of side Vision	y	N
Double Vision	y	N	Dryness	y	N
Mucous Discharge	y	N	Redness	y	N
Sandy or gritty feeling	y	N	Itching	y	N
Burning	y	N	Foreign body sensation	y	N
Excess tearing/watering	y	N	Occasional tearing,	y	N
Glare/light sensitivity	y	N	Eye pain or soreness	y	N
Sties, chalazion	Y	N	Chronic infection of eye or lid	Y	N

Explain "Yes" answers: _____

RESPIRATORY

Asthma	Y	N
Emphysema/COPD	Y	N
Bronchitis	Y	N
Chronic Cough	Y	N
Seasonal Allergies	Y	N
Tuberculosis	Y	N
Pneumonia	Y	N
Shortness of Breath	Y	N
Smoking History	Y	N
Other _____	Y	N

CARDIOVASCULAR

High Blood Pressure	Y	N
Low Blood Pressure	Y	N
Heart Attack	Y	N
Chest Pains/Angina	Y	N
Heart Murmur	Y	N
Congestive Heart Failure	Y	N
Irregular Heart Beat	Y	N
Migraines	Y	N
Slow or Fast Heart Rate	Y	N
Bleeding Problems	Y	N
Stroke/TIA's	Y	N
Other blood or lymphatic	Y	N

SYSTEMIC

Diabetes	Y	N	Intestinal/Bowel Problems	Y	N
Thyroid	Y	N	Cancer	Y	N
Kidney Disease	Y	N	Arthritis	Y	N
Hepatitis/Yellow Jaundice	Y	N	Other Musculoskeletal	Y	N
Convu Is ions/Se izures/			Other Skin Problems	Y	N
Blackouts	Y	N	Other Neurological Problems	Y	N
Hiatal Hernia	Y	N	Other Psychiatric	Y	N
Stomach Ulcers	Y	N	Other Eyes, Nose, Throat	Y	N
HIV/AIDS	Y	N	Other Gastrointestinal	Y	N
			Other Genitourinary	Y	N

Explain "Yes" answers: _____

(see other side)

II Past History

List any medications you take: _____

_____

List all major illnesses or injuries you have had in the past: _____

_____

List all surgeries you have had in the past _____

_____

Do you have allergies to any medications? Y N If "Yes", list medications and type of reaction: _____

_____

III. Family History

Blindness	Y	N	Relationship to You _____
Crossed or Lazy Eye	Y	N	Relationship to You _____
Cataracts	Y	N	Relationship to You _____
Glaucoma	Y	N	Relationship to You _____
Macular Degeneration	Y	N	Relationship to You _____
Retinal Detachment	Y	N	Relationship to You _____
Arthritis.	Y	N	Relationship to You _____
Cancer	Y	N	Relationship to You _____
Diabetes	Y	N	Relationship to You _____
Heart Attack	Y	N	Relationship to You _____
High Blood Pressure	Y	N	Relationship to You _____
Other	Y	N	Relationship to You _____

IV. Social History

Current Occupation: _____

Do you drive?	Y	N	
Do you have visual difficulty when driving?	Y	N	
Do you have a problem with night vision?	Y	N	
Have you ever tried to wear contacts?	Y	N	
Do you currently wear glasses?	Y	N	How long have you had your current pair? _____
Do you drink alcohol?	Y	N	If so, how frequently? _____
Do you smoke?	Y	N	If so, how many packs a day? _____

Please list any additional pertinent information: _____

Initial Review by: _____ Date: _____

PATIENT QUESTIONNAIRE

I. PLEASE LIST THE FAMILY MEMBERS OR OTHER PERSONS, IF ANY, WHOM WE MAY INFORM ABOUT YOUR GENERAL MEDICAL CONDITION AND YOUR DIAGNOSIS:

_____

_____

II. PLEASE LIST THE FAMILY MEMBERS OR SIGNIFICANT OTHERS, IF ANY, WHOM WE MAY INFORM ABOUT YOUR MEDICAL CONDITION ONLY IN AN EMERGENCY:

_____

_____

III. PLEASE PRINT THE ADDRESS OF WHERE YOU WOULD LIKE YOUR **BILLING STATEMENTS** AND/OR CORRESPONDENCE FORM OUR OFFICE TO BE SENT IF OTHER THAN YOUR HOME:

_____

_____

IV. PLEASE INDICATE IF YOU WANT ALL CORRESPONDENCE FROM OUR OFFICE SENT IN A SEALED ENVELOPE MARKED "CONFIDENTIAL":

YES _____ NO _____

V. PLEASE PRINT THE TELEPHONE NUMBER, IF ANY, WHERE YOU WANT TO RECEIVE CALLS ABOUT YOUR APPOINTMENTS, LAB AND X-RAY RESULTS, OR OTHER HEALTH CARE INFORMATION IF OTHER THAN YOUR HOME PHONE NUMBER:

(_____) _____

VI. CAN CONFIDENTIAL MESSAGES (I.E. **APPOINTMENT REMINDERS)** BE LEFT ON YOUR HOME ANSWERING MACHINE OR VOICEMAIL?

YES _____ NO _____

VII. IF YOU DO NOT HAVE VOICEMAIL, CAN A CONFIDENTIAL MESSAGE BE LEFT AT YOUR PLACE OF EMPLOYMENT?

YES _____ NO _____

PATIENT NAME _____

SIGNATUREX _____DATE _____

PATIENT AND/OR GUARDIAN

MEDICAL-SURGICAL EYE CARE, P. A.
PATIENT ACKNOWLEDGEMENT
OF HAVING READ OR BEEN READ THE
NOTICE OF HEALTH INFORMATION PRACTICES

I HAVE BEEN PROVIDED THE OPPORTUNITY TO READ, OR IT HAS BEEN READ TO ME, THE NOTICE OF HEALTH INFORMATION PRACTICES AT MEDICAL-SURGICAL EYE CARE, P.A.

I UNDERSTAND THAT MEDICAL-SURGICAL EYE CARE, P. A. IS COMMITTED TO TREATING AND USING PROTECTED HEALTH INFORMATION ABOUT ME RESPONSIBLY.

I UNDERSTAND MY RIGHTS AS IT RELATES TO MY RECORDS AT MEDICAL-SURGICAL EYE CARE, P. A. AND UNDERSTAND HOW INFORMATION ABOUT ME MAY BE USED AND DISCLOSED.

I UNDERSTAND THAT MY HEALTH RECORD IS THE PHYSICAL AND LEGAL PROPERTY OF MEDICAL-SURGICAL EYE CARE, P. A. , BUT THE INFORMATION BELONGS TO ME. I MAY HAVE ACCESS TO INSPECT, AMEND OR OBTAIN A COPY OF MY HEALTH INFORMATION. COSTS WILL INCUR FOR COPIES OF MY RECORDS, AND APPOINTMENTS MUST BE MADE WITH THE PRIVACY OFFICER TO INSPECT, ACCESS OR AMEND MY HEALTH INFORMATION.

I UNDERSTAND THAT MEDICAL-SURGICAL EYE CARE, P.A. IS REQUIRED TO MAINTAIN THE PRIVACY OF MY HEALTH INFORMATION. MEDICAL-SURGICAL EYE CARE, P.A. WILL REQUIRE MY AUTHORIZATION TO RELEASE MY HEALTH INFORMATION TO OUTSIDE SOURCES WITH THE EXCEPTION OF DISCLOSURES FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS. THESE MAY INCLUDE: ACCESS TO MY HEALTH INFORMATION BY MEDICAL-SURGICAL EYE CARE, P.A. STAFF AND PHYSICIANS; BILLING TO MYSELF OR A THIRD-PARTY PAYER; IN ADDITION, BUSINESS ASSOCIATES OF MEDICAL-SURGICAL EYE CARE P.A. MAY FROM TIME TO TIME HAVE ACCESS TO MY HEALTH INFORMATION, BUT I AN ASSURED THAT PROPER BUSINESS ASSOCIATES AGREEMENTS ARE IN PLACE, INSURING THE PROTECTION OF MY HEALTH INFORMATION; UPON THE PHYSICIANS BEST JUDGMENT WE MAY DISCLOSE TO A FAMILY MEMBER, RELATIVE OF CLOSE PERSONAL FRIEND OR ANY OTHER PERSON YOU IDENTIFY, HEALTH INFORMATION RELEVANT TO THAT PERSON'S INVOLVEMENT IN MY CARE, MAY BE USED FOR RESEARCH OR LEGAL DATA, FUNERAL DIRECTORS; ORGAN PROCUREMENT; MARKETING, FDA, PUBLIC HEALTH OR LEGAL AUTHORITIES; AND/OR LAW ENFORCEMENT PURPOSES.

MEDICAL-SURGICAL EYE CARE,P.A. MAY CALL ME WITH APPOINTMENT REMINDERS, CANCELLATIONS AND MAY LEAVE VOICE MESSAGES AT MY HONE OR PLACE OF EMPLOYMENT.

I HAVE READ AND UNDERSTAND THE HEALTH INFORMATION PRACTICES OF MEDICAL-SURGICAL EYE CARE, P. A.