NAME: _____ REFERRING DOCTOR: _____

DATE: _____/_____/_____ MEDICAL DOCTOR: _____

DOB: _____ OCCUPATION: _____

DRUG ALLERGIES: _____

MEDICATIONS:

1. _____	6. _____	11. _____
2. _____	7. _____	12. _____
3. _____	8. _____	13. _____
4. _____	9. _____	14. _____
5. _____	10. _____	15. _____

MEDICAL HISTORY (CIRCLE Y/YES OR N/NO)

STROKE OR PARALYSIS	Y/N
ARTHRITIS OR RHEUMATOLOGIC DISEASE	Y/N
ASTHMA/EMPHYSEMA	Y/N
BRADYCARDIA (SLOW PULSE)	Y/N
DIABETES - TYPE 1 ( ) OR TYPE 2 ( )	Y/N
CANCER – SITE_____	Y/N
CONGESTIVE HEART FAILURE	Y/N
KIDNEY STONE	Y/N
HYPERTENSION (HIGH BLOOD PRESSURE)	Y/N
AIDS/HIV	Y/N
OTHERS:	Y/N

SOCIAL HISTORY

ALCOHOL-CONSUMPTION: _____	Y/N
SMOKE-HOW MUCH: _____	Y/N
FORMER SMOKER:	Y/N

FAMILY HISTORY	MOTHER	FATHER
RETINAL DETACHMENT	Y/N	Y/N
GLAUCOMA	Y/N	Y/N
DIABETES	Y/N	Y/N
RETINITIS PIGMENTOSA	Y/N	Y/N

OTHER: _____

OFFICE USE ONLY

REVIEW OF SYMPTOMS (CIRCLE ALL THAT 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 - INTESTINE PROBLEMS
MUSCLE - JOINT PAIN - ARTHRITIS
SKIN RASHES - SORES - RECURRENT INFECTIONS
WEAKNESS - NUMBNESS - SEIZURES
DEPRESSION - ANXIETY - AGITATION
EXCESSIVE THIRST - URINATION - HORMONE PROBLEMS
EASY BRUISING - BLEEDING - ANEMIA
SWOLLEN GLANDS - IMMUNE SYSTEM PROBLEMS
HAY FEVER - ALLERGIES

LIST SURGERIES: _____

_____

PATIENT'S SIGNATURE: _____

MIDATLANTIC OPHTHALMOLOGY

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

Last Name: _____First Name: _____ MI___ Marital Status: S M W D

Birthday: _____ Sex: M / F Height: _____ Weight: _____

Ethnicity: _____ Race: _____ Preferred Language: _____

Social Security# _____ E-mail Address: _____

Home phone _____ Cell phone _____

Street Address: _____City: _____ ST: _____Zip:_____

Patient's employer: _____Occupation: _____ Work Phone# _____

Employer's address: _____ City & State: _____ Zip: _____

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

Spouse or Parent's Employer: _____ Occupation: _____ Phone # _____

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

Have you or anyone in your family been here before: Yes___ No ___ which Doctor _____

How were your referred to this office: _____Family Doctor: _____

INSURANCE INFORMATION

Primary Insurance Co: _____ Address: _____

Subscriber's name: _____ Birth date: _____ ID# _____ Group# _____

Secondary Insurance Co: _____ Address: _____

Subscriber's name: _____ Birth date: _____ ID# _____ Group# _____

IF PATIENT IS NOT RESPOSIBLE 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 patient 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 services plans. Accordingly, the undersigned accepts full financial responsibility for all items or 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 arrangement 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 plan, I agree to pay them to Midatlantic Eye Center. I UNDERDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED IN THE EVENT THAT MY INSURANCE DENIES PAYMENT.

4. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to Midatlantic Eye Center for services furnished me by Midatlantic Eye Center. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services and its agent any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other insurance is indicated on the claim form, my 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 services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier. I AM RESPONSIBLE FOR THE 20% MEDICARE COPAY, ANY DEDUCTIBLES, AND NON COVERED SERVICES.

5. The doctors and staff of Midatlantic Eye Center have my permission to discuss my personal health information with: _____ _____
   Relationship

6. By my signature I acknowledge that the privacy policies and patient rights of the 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 or Authorized Party **Date**