

Community Eye Center

Name of Patient _____

Local Address _____

Out-of-State Address _____

Social Security _____ — — Home Phone () _____

Age _____ Sex _____ Date of Birth _____ Martial Status _____

Occupation _____ Employer _____

Employer's Address _____ Work Phone () _____

Responsible Party _____ Date of Birth _____ Relationship to Patient _____

Address _____

Home Phone () _____ Social Security Number _____ — —

Emergency Contact _____ Phone () _____

Primary Care Physician _____ PCP Phone _____

INSURANCE INFORMATION

Primary Insurance Carrier _____ Insurance Effective Date _____

Contract Number _____ Group Number _____

Subscriber Name (Policy Holder) _____ Subscriber's Date of Birth _____

Secondary Insurance Carrier _____ Effective Date _____

Contract Number _____ Group Number _____

Subscriber Name (Policy Holder) _____ Subscriber's Date of Birth _____

Patient Signature: _____ Date: _____

Relationship, if Guardian: _____

Signature of File, Assignment of Benefits, Financial Agreement

Beneficiary Name (Please Print)

Medicare Number

- 1. MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to Community Eye Center, for services furnished me by Community Eye Center. I authorize any holder of medical information about me to release to Centers for 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 that payment be made and authorizes release of medical information to pay the claim. If other health insurance is indicated in item 9 of the CMS 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Community Eye Center accepts the charge determination of the Medicare carrier as full charge, and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier
- 2. MEDIGAP:** I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the CMS 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer of the agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Community Eye Center, if possible or otherwise to me.
- 3. RELEASE OF INFORMATION:** Community Eye Center may disclose all or any part of my medical record and/or financial ledger, including information regarding 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 Community Eye Center for reimbursement for services rendered, and (2) any health care provider for continued patient care. Community Eye Center may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.
- 4. OTHER INSURANCE:** I understand that Community Eye Center maintains a list of health care services plans with which it contracts. And that Community Eye Center has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Community Eye Center if I belong to a plan that does not appear on the above-mentioned list.
- 5. NON-COVERED SERVICES:** I understand that Community 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 services plans not to be covered. Examples of non-covered services include, but are limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary of the plan. The undersigned agrees to cooperate with Community Eye Center to obtain necessary health care service plan authorizations.
- 6. FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by Community Eye Center I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Community Eye Center for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to Community Eye Center. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Community Eye Center. *However, it is understood that the undersigned and/or patient are primarily responsible for the payment of my bill.*

Beneficiary Signature or Authorized Party

Date

Medical History Questionnaire

Patient Number _____

Name: _____
 Name of Eye Doctor: _____
 Name of Medical Doctor: _____
 Social Security Number: _____

Today's Date: _____
 Last Eye Exam: _____
 Last Medical Exam: _____
 Dr's Phone: () - _____

Medical History

Do you have any allergies to medications? yes no If yes, explain: _____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies)

Medications	Medications	Medications	Updated

List any of the following that you have had: crossed eyes, lazy eyes, drooping eyelids, prominent eyes, glaucoma, retinal disease, cataracts, eye infections eye surgery or eye injury: _____

Are you pregnant and/or nursing: yes no
 Do you wear glasses: yes no If yes, how old is your present pair of glasses? _____
 Do you wear contact lenses: yes no If yes, how old is your present pair of lenses? _____
 Type of contact lenses: Rigid Soft Extended Wear Other Are they comfortable? _____
 Do you drive: yes no If yes, do you have visual difficulty when driving? _____

Family History

Where were you born: _____ What nationality/heritage are you: _____

Please note any family history (parents, grandparents, sisters, brothers, children: living or deceased) for the following

<u>Disease/Condition</u>	<u>yes</u>	<u>no</u>	<u>?</u>	<u>REL</u>	<u>Disease/Condition</u>	<u>yes</u>	<u>no</u>	<u>?</u>	<u>REL</u>
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—	Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—
Retinal Detachment/Dis.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—	Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	—					

Social History This information is kept confidential. If you prefer to discuss this directly with the doctor check here.

Do you use tobacco products:? Yes no If, yes, type/amount/how long: _____

Do you drink alcohol? Yes no If, yes, type/amount/how long: _____

Do you use illegal drugs? Yes no If, yes, type/amount/how long: _____

Have you ever been exposed or infected with? Gonorrhea yes no Hepatitis yes no

HIV yes no Syphilis yes no

Have you ever been exposed to any chemicals? yes no _____

Review of Systems

Constitutional yes no ?

Fever Weight Loss/Gain

Integumentary

Neurological

Headaches

Migraines

Seizures

Eyes

Loss of Vision

Blurred Vision

Distorted Vision/Halos

Double Vision

Dryness

Mucous Discharge

Redness

Sandy or Gritty Feeling

Itching

Burning

Foreign Body Sensation

Excess Tearing/Watering

Glare/Light Sensitivity

Eye Pain or Soreness

Sties or Chalazion

Flashes/Floaters in Vision

Tired Eyes

Endocrine

Thyroid/Other Glands

Allergic/Immunologic

Psychiatric

Ears, Nose, Mouth, Throat

yes no ?

Allergies/Hay Fever

Sinus Congestion

Runny Nose

Post-Nasal Drip

Chronic Cough

Dry Throat/Mouth

Respiratory

Asthma

Chronic Bronchitis

Emphysema

Vascular/Cardiovascular

Diabetes

Chest Pain

High Blood Pressure

Vascular Disease

Gastrointestinal

Diarrhea

Constipation

Genitourinary

Genitals/Kidney/Bladder

Bones/Joints/Muscles

Rheumatoid Arthritis

Muscle Pain

Joint Pain

Lymphatic/Hematological

Anemia

Bleeding Problems

If you have answered YES to any of the above or have a condition not listed, please explain & list medications:

Patient's Signature

Date

Doctor's Signature

Date