Eye Doctor, MD, P.C.

Patient Name: _____ Date of Birth: _____/_____/_____

Address: _____
Street City State Zip Code

Preferred Phone: □ Home □ Work □ Cell (_____)_____

Alternate Phone: □ Home □ Work □ Cell (_____)_____

SSN#_____-_____-_____ E-mail_____

Gender: □ Male □ Female Marital Status □ Single □ Married □ Divorced □ Widow □ Separated

Employer _____ Occupation_____

Retired □ No □ Yes Retired From_____

Impairments: □ Hearing □ Vision □ Mobility □ Other_____

Birth Country: □ USA □ Other _____ Primary Language: □ English □ Other:_____

Race/Ethnicity: □ White □ Black □ Hispanic/Latino □ Asian □ Prefer not to specify □ Other _____

Emergency Contact _____ Phone # _____

Relationship: □ Spouse/Partner □ Child □ Parent □ Other_____

Primary Care Physician _____ Phone #_____

Pharmacy Name _____ Phone #_____Zip Code_____

How did you hear about us? _____

When was your last eye exam? _____By whom? _____

Health Insurance Coverage (To be completed by ALL patients)

Primary Insurance: _____ ID#_____Group#_____

Policy Holder Name: _____ Relationship to Pt: □ Self, □ Spouse, □ Child _____

Policy Holder Date of Birth: ____/_____/____ SSN of Policy Holder _____

Secondary Insurance: _____ ID#_____Group#_____

Policy Holder Name: _____ Relationship to Pt: □ Self, □ Spouse, □ Child _____

Policy Holder Date of Birth: ____/_____/____ SSN of Policy Holder _____

Worker's Compensation

Employer's Name: _____ Contact Person: _____

Employer's Address: _____ Employer's Phone #_____

Date of Injury: _____/_____/_____ Claim # _____

Eye Doctor, MD, P.C.

Patient Name: _____ Date of Birth: _____/_____/_____

I, _____, was offered and:
(Printed Name of Patient or Patient Representative)

□ I have received a copy of the "Notice of Privacy Practices" for Eye Doctor MD, P.C. (available online)

□ I declined a personal copy of the "Notices of Privacy Practices" Eye Doctor MD, P.C.

As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy. This notice is posted in our offices, on our website and copies are available at any time. I understand that I may ask questions of Eye Doctor MD, P.C. if I do not understand any information in the Notice of Privacy Practices. The summary is that we do not use or sell your information to any companies for any purpose. Your information is only used for your medical care.

AUTHORIZATION FORM FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. We have explained that disclosures may be made to family and friends related to the patient's health. It has also been explained that we will only disclose information relevant to current treatment. By signing below I authorize Eye Doctor MD, P.C. to disclose health care information to the following individuals (list all that apply):

	Name	In Person	By Phone	Ok to leave Voicemail	Effective Today	Effective Until
Spouse/Partner						
Parent						
Sibling						
Child						

Please initial the applicable items below: Eye Doctor MD, P.C. staff have my permission to leave
□____ Appointment Information □ ____ Medical Information □ ____ No information
from our Practice on my □ ____ cell phone voice-mail, □ ____ home voice-mail, □ ____ work voice-mail.

_____ _____
(Signature of Patient) (Date)

_____ _____
(Signature of Patient's Representative) (Date)

_____ _____
(Printed Name of Patient's Representative) (Relationship to Patient)

Eye Doctor, MD, P.C.

Patient Name: _____ Date of Birth: _____/_____/_____

Patient Health and Medical History Form

- **Cardiovascular:**
  - □ High blood pressure
  - □ High cholesterol
  - □ Heart Attack/Failure _____
  - □ Heart Surgery_____
  - □ Arrhythmia
  - □ Carotid Artery Disease
  - □ Peripheral Vascular Disease
- **Lung Disease:**
  - □ Asthma □ Use inhaler
  - □ COPD
  - □ Tuberculosis (TB)
  - □ Other _____
- **Urinary:**
  - □ Kidney Disease
  - □ Kidney Stones
  - □ Bladder disease
- **Endocrine:**
  - □ Diabetes (diagnosed in _____)
    - □ Insulin Dependent
    - □ Oral medication
    - □ Diet controlled
  - □ Thyroid disease □ Low □ High

    _____
- **Rheumatologic:**
  - □ Rheumatoid arthritis
  - □ Lupus
  - □ Sarcoidosis
  - □ Other_____
- **Blood Disease**
  - □ Sickle Cell / Anemia / Leukemia
  - □ HIV
  - □ Other _____
- **Psychiatric Disorder**
  - □ Depression / Anxiety
  - □ Schizophrenia
  - □ Bipolar
  - □ other _____
- **Neurological:**
  - □ Developmental Delay, Autism
  - □ Alzheimer's Dementia
  - □ Traumatic Brain Injury
  - □ Stroke _____
  - □ Paralysis
  - □ Headaches/Migraines
  - □ Brain Tumor / Pituitary Tumor
- **Skin Disease**
  - □ Cancer / Melanoma
  - □ Rosacea
  - □ Psoriasis
  - □ Other _____
- **GI - Gastrointestinal:**
  - □ GERD Reflux, Ulcer
  - □ Gallbladder, Appendix, Colon, IBS
  - □ Hepatitis B, Hepatitis C
- **GU - Genitourinary:**
  - □ Uterine Disease / Ovarian Disease
  - □ Breast Disease _____
  - □ Prostate Problems_____
- **Ear, Nose, and Throat:**
  - □ Hearing Loss
  - □ Sinus
  - □ Throat Disease
  - □ Cancer
- **Reproductive**:
  Women: □ Pregnant _____ months,
  □ Recent Delivery, □ Nursing _____ months

Social History:

- Tobacco: □ None, □ Yes _____ pack/day
  □ Quit, when_____?
- Alcohol: _____ drinks per week.
- Drug use: □ Marijuana, □ Cocaine, □ Heroin, □ other _____, If stopped when? _____

Reviewed by Doctor: _____

3960 Stillman Parkway, Suite 120, Glen Allen, Virginia 23060
Phone. 804-270-3333, Fax. 804-270-9333, www.eyedoctormd.org

Eye Doctor, MD, P.C.

Patient Name: _____ Date of Birth: _____/_____/_____

Family History **(Please specify Maternal or Paternal)**

- □ Glaucoma _____
- □ Glaucoma Suspect _____
- □ Cataracts at a young age (under 60) _____
- □ Retina Problems:
  - ○ Macular Degeneration,
  - ○ Retinal Tear / Retinal Detachment
  - ○ Other:._____
- □ Other Eye Problems: _____
- □ Diabetes _____
- □ Heart attack _____
- □ Stroke_____
- □ Cancer_____
- □ Other:_____

Surgical History: □ None □ Pacemaker

_____

_____

_____

Ocular/Eye History

- □ Blurry Vision
- □ Itching / Burning
- □ Dry eye disease / Meibomian gland dysfunction
- □ Redness
- □ Watering
- □ Floaters / Flashing Lights
- □ Glare with driving
- □ Glaucoma / Glaucoma Suspect
- □ High eye pressure
- □ Cataracts at a young age
- □ Macular degeneration
- □ Retinal Tear / Retinal detachment
- □ Laser surgery
- □ Cataract surgery _____
- □ LASIK or PRK _____
- □ Other _____
- □ Wear glasses: all the time / driving / reading
- □ Wear contact lenses: all the time / monovision

Medications: □ None □ See list

_____

_____

_____

_____

Allergies: □ None □ Seasonal □ Food

_____

_____

_____

Review of Systems: □ Generally Healthy

General: □ Any weight change_____?
□ Fevers? □ Chills?

Head: □ Headaches? □ Dizziness? □ Injury?

Ears: □ Change in hearing? □ Ringing in ears?

Nose: □ Bleeding? □ Sinus congestion?

Mouth: □ Ulcers? □ Bleeding? □ Dentures?

Neck: □ Stiffness? □ Pain? □ Tenderness? □ Masses? □ Swelling?

Breast: □ Cancer? □ Tenderness? □ Swelling?

Chest: □ Trouble breathing? □ Wheezing? □ Cough? □ Coughing blood?

Heart: □ Chest pains? □ Palpitations? □ on blood thinners: □ Aspirin, □ Plavix, □ Coumadin □ Other

Abdomen: □ Pain? □ Nausea? □ Vomiting? □ Diarrhea? □ Constipation? □ Liver problems?

GU: □ Trouble urinating? □ Kidney disease? □ Blood in urine? □ on Flomax?

Musculoskeletal: □ Pins/ needles feeling? □ Weak? □ Numb? □ Back pain? □ Joint pain?

Skin: □ Rash? □ Pigmentation changes?

Neurologic: □ Weakness? □ Tremor? □ Seizures? □ Changes in mentation?

Psychiatric: □ Depressive symptoms? □ Changes in sleep habits? □ Changes in thought content?

Other: □ _____

Reviewed by Doctor: _____

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Eye Doctor, MD, P.C.

Patient Name: _____ Date of Birth: _____/_____/_____

CONSENT FOR TREATMENT
I authorize *Eye Doctor MD, PC* to provide medical treatment to myself and or my dependent.

ASSIGNMENT OF BENEFITS - I request that payment of authorized Medicare, Medicaid or applicable private insurance benefits be paid directly to Eye Doctor MD, PC for services provided under their care.

RELEASE OF MEDICAL INFORMATION - I authorize Eye Doctor MD, PC to release necessary medical information to my insurance company, its agents, or any third party payer in order for payable benefits for these services to be determined.

COLLECTION OF CO-PAYS AND DEDUCTIBLES - Per our agreement with your insurance carrier, you are required to pay any applicable copayments at the time of service. In addition, if you are insured with a high deductible insurance plan and have not met your deductible, we will collect $200 up front at the time of service. It is your responsibility to understand your agreement with your insurance company and any copayments and deductibles to be paid by you when seeing a specialist.

FINANCIAL RESPONSIBILITY - I understand that Eye Doctor MD, PC will file my insurance claims as a courtesy; however, I am ultimately responsible for full payment of all charges. Should collection proceedings or other legal action become necessary to collect an overdue account, the patient or the patient's responsible party, understands that Eye Doctor MD PC has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The patient, or the patient's responsible party, understands and agrees to pay all collection fees in the amount up to thirty-three and one-third percent (33-1/3%) of the total unpaid balance due, plus court costs and filing fees incurred by Eye Doctor MD, PC. I understand and agree that should Eye Doctor MD, PC be awarded judgment relating to this agreement or any debt incurred thereof, I will pay a service charge of one and one-half percent (1-1/2%) per month, eighteen percent (18%) per annum, beginning on the date of judgment.

REFERRALS/AUTHORIZATIONS - I understand if my insurance company requires a referral, I am responsible for obtaining a referral prior to my visit. If I do not have a referral I will be required to sign a waiver before being seen by the physician and payment in full for services rendered will be collected at the check-out desk.

MISSED APPOINTMENTS - We require at least 24 hours' notice if you must cancel an appointment, failure to do so may result in a $25 "no show" fee.

RETURNED CHECKS - Our office will charge $25 for any check that is returned for insufficient funds.

I have read the above statements and I understand my responsibilities. I acknowledge that Eye Doctor MD, PC, will scan this document and destroy the original, and agree the scanned document is the same as the original.

_____ _____
Signature of Patient or Responsible Party (Date)

_____ _____
Printed Name of Patient or Responsible Party Relationship to Patient

Eye Doctor, MD, P.C.

Patient Name: _____ Date of Birth: _____/_____/_____

Refraction Form

The Refraction is the part of the eye exam when we determine your eyeglasses prescription ("Which is better, One or Two"). This is an essential part of any eye exam even if you do not plan to update your glasses. We recommend strongly that refraction be performed as part of any eye exam since it helps us determine your best corrected vision. In doing so, we can better assess the health status of your eyes. Most insurance companies (including Medicare and Medicaid) do not cover the refraction fee. You are responsible for the refraction fee if your insurance company does not cover this service. I have been notified that the services identified may not be a covered benefit by my insurance and payment is expected when services are rendered. *I agree to be personally and fully responsible for payment if I am given a prescription for glasses, contact lenses or both.*

Patient Signature:_____

□ _____ I want a refraction ($65.00)

□ _____ I want a refraction and contact lens fitting ($65+$35 = $100.00)

If not paid at time of service, $10 additional billing charge will be added

E-Prescribing Form

ePrescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care.

Benefits data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBM's are third party administrators of prescription drugs programs whose primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan. The Medicare Modernization Act (MMA) 2—3 listed standards that have to be included in an ePrescribe program. These include:

- I understand that Eye Doctor MD, P.C. may access the Virginia Prescription Monitoring Program (PMP) without specific patient consent.
- **Formulary and benefit transactions—**Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions—**Provides the physician with information about medications the patient is already taking prescribed by any provider, to minimize the number of adverse drug events. By signing this consent form you are agreeing that Eye Doctor, M.D., P.C. can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

Patient Signature:_____

Referral Waiver – Required if your insurance requires a referral (HMO policy)

I did not bring a referral for the medical services I will receive today. If my primary care physician does not provide a referral, I understand that I am responsible for paying for the services I am provided.

Patient Signature:_____