PATIENT INFORMATION (PLEASE PRINT)

Name _____ Date of Birth _____/_____/_____

Address _____

City _____ State _____ Zip _____

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

M/F_____ Social Security #_____ /_____ /_____

Email Address: _____

Employer / If child, parent's employer _____ Occupation _____

Work Address _____

Spouse Name _____ Employer _____

Work Address _____

Your Primary Physician _____ Your Cardiologist _____

Pharmacy_____ Phone number/and/or address _____

Referred by: Friend/Relative _____ Doctor _____

If you are seeing Dr. Fountain, who is your general ophthalmologist?_____

Are you personally responsible for the payment of your fees? _____ Yes _____ No

If no, who is? _____ Relationship _____

Primary Insurance _____ Secondary Insurance _____

Name of Insured _____

Insured Date of Birth _____ /_____ /_____ Insured Social Security # _____ - _____ - _____

PLEASE MAKE SURE THE FRONT DESK HAS A COPY OF YOUR CURRENT MEDICAL INSURANCE CARD. (WE ARE NOT ON ANY VISION PLANS.)

In compliance with Ophthalmology Partners Ltd.'s participation in a government program on patient quality of care we ask that you provide the following information. (Please note that you have the option to decline to answer these questions.)

Race: ❑ African-American ❑ American Indian ❑ Asian ❑ Caucasian ❑ Native Hawaiian ❑ Unknown ❑ Other Race

Preferred Language:_____

Ethnicity: ❑ Hispanic ❑ Non-Hispanic ❑ Unknown

If this is a workman's compensation case:

Company _____ Contact Person _____

Address _____

Phone Number _____

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ **Date of Birth:** _____ **Age:** _____ **Date:**_____

Sex: Male / Female Primary Care Physician: _____

CONDITIONS:	Circle any and all conditions that apply to you or check none.	NONE
GENERAL:	fever, heat stroke, weight loss, weight gain, fatigue, insomnia, headaches, other _____	
EARS, NOSE, THROAT:	hard of hearing, earache, cough, dry mouth, sinus, allergy, hoarseness, vertigo, tinnitus, other _____	
CARDIOVASCULAR:	high B/P, heart attack, chest pain, congestive heart failure, racing pulse, high cholesterol, irregular heartbeat, palpitations, pace maker, murmur, a-fib, other _____	
RESPIRATORY:	congestion, wheezing, short of breath, asthma, COPD, emphysema, other _____	
GASTROINTESTINAL:	stomach upset, diarrhea, constipation, hernia, ulcers, nausea, GERD, Crohn's disease, other _____	
GENITOURINARY:	painful/ frequent urination, impotence, incontinence, jaundice, kidney stones, blood in urine, other _____	
FEMALES:	Are you pregnant?_____ Are you nursing?_____	
MUSCULOSKELETAL:	joint pain, stiffness, swelling, cramps, fibromyalgia, rheumatoid arthritis, lupus, other type arthritis, osteoporosis, other _____	
DERMATOLOGIC:	acne, psoriasis, eczema, warts, growths, skin rash, rosacea, skin cancer: type _____; other _____	
NEUROLOGICAL:	numbness, headache, seizures, paralysis, stroke, dementia, memory loss, Alzheimer's, Parkinson's, ADHD , other _____	
PSYCHIATRIC:	anxiety, depression, schizophrenia, other _____	
ENDOCRINE:	diabetes: type I, type II; hypothyroid, hyperthyroid, Graves disease, thyroid eye disease, hypoglycemia, postmenopausal, other _____	
HEMATOLOGY:	bleeding, anemia, blood clots, other _____	
ALLERGIC/IMMUNOLOGIC:	sinus, seasonal allergies, swelling, redness, itching, hives, lupus, HIV, herpes simplex virus, Sjogren's syndrome, rheumatoid arthritis, multiple sclerosis , other _____	
CANCER:	leukemia, breast, prostate, lung, skin, colon, skin, other _____	
EYES:	dry eye, punctal plugs, cataract, glaucoma, detached retina, blindness, lazy eye, eye injury/trauma, corneal problems, macular degeneration, double vision, other _____	

List all Eye Surgeries & Laser Eye Surgeries:

_____

_____

List all other relevant surgeries you have had:

_____

_____

FAMILY HISTORY: Has any member of your immediate family (blood relatives) have/had these diseases?

Disease/Condition			Family Member	Disease/Condition			Family Member
Lazy Eye	yes	no	Mother Father Sibling Grandparent	Heart Disease	yes	no	Mother Father Sibling Grandparent
Macular Degeneration	yes	no	Mother Father Sibling Grandparent	Hypertension	yes	no	Mother Father Sibling Grandparent
Blindness	yes	no	Mother Father Sibling Grandparent	Stroke	yes	no	Mother Father Sibling Grandparent
Retinal Disorders	yes	no	Mother Father Sibling Grandparent	Thyroid Disease	yes	no	Mother Father Sibling Grandparent
Cataracts	yes	no	Mother Father Sibling Grandparent	Arthritis	yes	no	Mother Father Sibling Grandparent
Glaucoma	yes	no	Mother Father Sibling Grandparent	Cancer	yes	no	Mother Father Sibling Grandparent
Diabetes	yes	no	Mother Father Sibling Grandparent	Type of Cancer: _____			

MEDICAL HISTORY QUESTIONNAIRE

Patient Name:_______________________________Date of Birth:______________Date:_____________

SOCIAL HISTORY: Please circle what applies

Employment Status:	Marriage Status:	Tobacco Use:	Alcohol Consumption:
Student	Single	Current Every Day Smoker	Never
Homemaker	Married	Current Some Day Smoker	Occasionally
Employed	Separated	Heavy Smoker	Daily
Retired	Divorced	Light Smoker	Heavily
	Widowed	Never Smoker	
		Former Smoker	

DO YOU HAVE ANY DRUG ALLERGIES? ☐ **Yes** ☐ **No** **If yes, please list** ___________________________

DO YOU TAKE ANY MEDICATIONS? ☐ **Yes** ☐ **No** **(If you checked yes, please list medications below)**

List all Prescriptions and Over the Counter medications you are taking: (Including eye drops, aspirin and ibuprofen)

If you have a list, please give to receptionist to copy in lieu of filling out form: **REVIEWED:**

Medication Name	Dosage	Taken how often? PRN= when needed	Route	Reason for taking	Currently Taking Yes	No
		____ Times a day ____ or PRN	__ Oral __ Topical __ Injection			
		____ Times a day ____ or PRN	__ Oral __ Topical __ Injection			
		____ Times a day ____ or PRN	__ Oral __ Topical __ Injection			
		____ Times a day ____ or PRN	__ Oral __ Topical __ Injection			
		____ Times a day ____ or PRN	__ Oral __ Topical __ Injection			
		____ Times a day ____ or PRN	__ Oral __ Topical __ Injection			
		____ Times a day ____ or PRN	__ Oral __ Topical __ Injection			
		____ Times a day ____ or PRN	__ Oral __ Topical __ Injection			
		____ Times a day ____ or PRN	__ Oral __ Topical __ Injection			

Staff	*Date*

All information you provide is confidential and will not be released to anyone without your consent. Use back of this form for any additional information that you need to add.

Notice of Privacy Practices Acknowledgement/Phone Message and Contact Authorization

Patient Name _____ **Date of Birth:** _____

The **Notice of Privacy Practice (NPP)** tells you how we may use and share your health records. It also describes your rights with respect to your health records. **Please read it.**

- We will use and share your health records to treat you and to bill you for the services we provide.
- We will use and share your health records to run our business.
- We will use and share your health records as required/allowed by law.

I understand that the NPP is available at the front desk of Ophthalmology Partners, Ltd.
I acknowledge receipt of the Notice of Privacy Practices (NPP).

Signature of Patient: _____ Date: _____

Signature of Authorized Representative: _____ Date: _____

Name of Authorized Representative: _____ Relationship: _____

Phone Message and Contact Authorization: Please CHECK the appropriate answer below:

Do the physicians and staff of Ophthalmology Partners, Ltd. have your permission to leave messages containing medical and/or financial information on your **answering machine?**

At home	☐ **Yes**	☐ **No ***
At work	☐ **Yes**	☐ **No ***
On cell	☐ **Yes**	☐ **No ***

* IF YOU CHECK "NO", ONLY THE DATE, TIME AND LOCATION OF APPOINTMENTS WILL BE LEFT ON YOUR ANSWERING MACHINE.

The individual(s) named below will also be your emergency contact(s) unless you specify otherwise.
Please complete below: **I give authorization to the doctors and staff of Ophthalmology Partners, Ltd. to discuss my medical and/or financial information with the following people:**

	Name	Relationship	Phone
(1)	_____	_____	_____
(2)	_____	_____	_____
(3)	_____	_____	_____

I understand that it is my responsibility to inform Ophthalmology Partners, Ltd. of any desired changes in this authorization.

Signature: _____ Date: _____

Ophthalmology Partners, Ltd.

FINANCIAL POLICY

Our office is happy to submit to your insurance for you. In order to do this, you must present your insurance card to our staff so that we may make a copy of it for your file. The following is our financial policy:

I request that payment of authorized Medicare, and/or insurance benefits be made on my behalf for any services furnished me.

I understand that I am financially responsible to Ophthalmology Partners, Ltd. for any covered or non-covered services as defined by my insurer. It is my responsibility to know my insurance benefits. It is my responsibility to pay any deductible amount, co-insurance, non-covered service, or any other balance not paid for by my insurance. Copays and refraction fees are due at the time of visit.

If payment is not received from the insurance carrier within 90 days, Ophthalmology Partners, Ltd. has the right to bill you directly.

If my insurance policy requires a referral, it is my responsibility to present it at the time of my visit. If failure to present this referral at the time of service results in a loss of benefits, I will be responsible for payment of all fees.

I am responsible for verifying that my provider is part of my insurance plan. If my insurance is an out of network provider, I will be responsible for payment of all fees.

I understand that if I am billed for over 3 billing cycles a $25 charge will be added to my balance. If my account is referred to a collection agency, a collection fee of 30% of the overdue balance will also be added to the amount due. I understand that I am financially responsible for the added collection fees and any reasonable attorney's fee and other costs incurred for the collection.

Signed _____ Date _____
(Patient or parent for minor)

Consent for use for visual images

I hereby give permission to Ophthalmology Partners Ltd., (the corporation) to photograph, videotape, or otherwise illustrate my clinical condition and to use this material on paper, film, or in electronic and internet transmission as deemed advisable for diagnostic, therapeutic, educational, or research purposes. I further give permission for the use of this material to illustrate scientific papers, books, or lectures at any time hereafter without inspection or approval, on my part, of the finished product or specific use to which this material may be applied. It is understood that in no way will I be identified by name. I hereby release and hold harmless Ophthalmology Partners Ltd., and all its participating physicians from all claims of liability, loss or expense which may result from activities authorized by this agreement.

Patient_____

Date_____

Consent for electronic communications

In order to give you the best care possible, your doctor may need to communicate with your referring doctor or other doctors about your health care history. Electronic mail is often the most efficient method of communication. We take steps to ensure the confidentiality of your health information but security breaches are always a remote and unlikely possibility. By signing below, you give permission, when necessary, for your doctor, to communicate electronically with other physicians that are part of your health care team in order to coordinate your treatment plan.

Patient_____

Date_____