Oculoplastic & Orbital consultants

PATIENT INFORMATION FORM

PATIENT DATA

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____ Social Security [last 4 digits]: _____ ☐ Female ☐ Male

Occupation: _____ Employer: _____

PREFERRED METHOD OF CONTACT

Home phone: _____ Preferred phone number ☐ Home ☐ Mobile

Mobile phone: _____ Is it ok to leave a detailed message? ☐ Yes ☐ No

Email: _____ Is it ok to email a detailed message? ☐ Yes ☐ No

Preferred method for appointment reminders? ☐ Text ☐ Phone ☐ Email

ADDRESS

Mailing Address: _____

City: _____ State: _____ Zip: _____

Billing Address *(if different)*: _____

City: _____ State: _____ Zip: _____

PHARMACY

Pharmacy name: _____ Pharmacy phone: _____

Pharmacy address/cross streets: _____

REFERRING PHYSICIAN

Physician Name/Practice: _____ Phone: _____

If not referred by a doctor, how did you hear about our Practice? _____

PRIMARY CARE PHYSICIAN

Physician Name/Practice: _____

Phone: _____ Fax: _____

INSURANCE

Primary Insurance: _____ Member ID: _____

Secondary Insurance: _____ Member ID: _____

PATIENT FINANCIAL POLICY

Oculoplastic and Orbital Consultants ("OOC") is committed to meeting all of your healthcare needs and it is our goal to keep insurance and financial matters as simple as possible. With that said, we ask that you adhere to the following guidelines:

INSURANCE: For those patients who are covered by insurance, OOC will verify your benefits and coverage prior to your visit, however, there is no guarantee that your insurance company will pay for services rendered by our facility. Insurance coverage is a contract between the patient and the insurance company. You will be expected to provide us with up to date demographics and insurance information at each visit so that we can file an insurance claim on your behalf. After insurance payments and contractual adjustments are applied to your account, any remaining balance will become your responsibility and payment will be due in full within 30 days. If you are unable to make the payment in its entirety, please contact our billing department to arrange a payment plan.

CO-PAYMENTS AND NON-COVERED SERVICES: All health plans are unique in their coverage and it is important to understand the benefits of your specific plan. Co-pays, deductibles and co-insurance as specified by your policy will be collected at the time of service and cannot be waived. If you cannot make the required payment, your appointment may be rescheduled. For patients who do not have insurance or request a service that is not covered by their health plan (cosmetic), we require that payment be made in full at the time of service. For your convenience, we accept cash, Visa, Mastercard, American Express, Discover and personal checks.

REFERRALS: If your health plan requires that you have a referral from your primary care physician in order to be seen at our practice, we will fax the initial request on your behalf, however it is your responsibility to follow up with your PCP and verify that the referral has been received by our office prior to your visit. If we do not have your referral at the time of the visit, your appointment may be rescheduled until a valid referral is obtained. Referrals typically have an expiration date and a limited number of visits so we ask that you take the responsibility to monitor your referral status.

APPOINTMENT CANCELLATIONS/NO SHOWS/LATE POLICY: As a courtesy to our patients on the waitlist, please give our office at least 48 hr notice if you need to cancel or reschedule your appointment. Failure to give us proper notice or not showing up for your appointment, may result in a charge of $25 to your account, and you will be asked for payment to be made before another appointment can be scheduled. Patients who arrive late for their appointments can cause a disruption to the planned schedule. Any patient arriving more than 15 minutes late may have to wait to be seen in order that we keep a timely schedule. Late patients may also be given the option of rescheduling their appointment. Patients arriving on time will always be given priority on the schedule.

OUTSIDE FEES: Tests which are referred to an outside facility, such as pathology, laboratory or other diagnostic testing will be billed separately and any questions concerning payments due should be addressed with them directly.

INSURANCE AUTHORIZATION AND ASSIGNMENT: I request that all authorized medical and surgical benefits to which I am entitled, be made either to me or on my behalf to "OOC" for any services performed by the provider. I authorize OOC to release any medical information needed to determine these benefits and to process claims, to the insurance company or to CMS (Centers for Medicare and Medicaid Services). I understand that my signature is a contract for commitment of payment for all medical and surgical services rendered by the provider and I am responsible for any amount not covered by my insurance benefits.

I have read and understand the above patient financial policy for Oculoplastic & Orbital Consultants and accept all of the terms and conditions as stated above.

Signature of Patient

Date

PATIENT HEALTH QUESTIONNAIRE

PATIENT DATA

Last Name: _____ First Name: _____ Middle Initial: _____

PAST MEDICAL HISTORY [please check all that apply]

- ☐ anginal syndrome
- ☐ anxiety
- ☐ arthritis
- ☐ asthma
- ☐ bleeding disorders
- ☐ cancer
- ☐ cardiac arrhythmia
- ☐ carotid disease
- ☐ circulation problems
- ☐ congestive heart failure
- ☐ COPD
- ☐ diabetes
- ☐ emphysema
- ☐ hearing loss
- ☐ heart attack
- ☐ hepatitis
- ☐ high blood pressure
- ☐ HIV/AIDS
- ☐ hypercholesterolemia
- ☐ immune deficiency
- ☐ joint replacement
- ☐ leukemia
- ☐ lung cancer
- ☐ lymphoma
- ☐ nerve palsy
- ☐ prostate disorder
- ☐ sinus problems
- ☐ shortness of breath
- ☐ previous stroke
- ☐ thyroid disease

☐ other _____

PAST SURGERIES

Have you had any previous surgeries other than OCULAR surgery? If so, what and when?

_____ _____
type of surgery year type of surgery year

OCULAR HISTORY [please check all that apply]

- ☐ allergic conjunctivitis
- ☐ blepharitis
- ☐ dry eyes
- ☐ ophthalmic migraine
- ☐ strabismus
- ☐ none
- ☐ other _____
- ☐ cataract (left eye ___, right eye ___)
- ☐ corneal dystrophy (left eye ___, right eye ___)
- ☐ diabetic retinopathy (left eye ___, right eye ___)
- ☐ glaucoma (left eye ___, right eye ___)
- ☐ macular degeneration (left eye ___, right eye ___)
- ☐ narrow angles (left eye ___, right eye ___)
- ☐ retinal detachment (left eye ___, right eye ___)
- ☐ vitreous floaters (left eye ___, right eye ___)

OCULAR SURGERY [please check all that apply]

- ☐ blepharoplasty (upper____, lower ____)
- ☐ ptosis repair (left eye ___, right eye ___)
- ☐ punctal plugs (left eye ___, right eye ___)
- ☐ Lasik (left eye ___, right eye ___)
- ☐ none
- ☐ other _____
- ☐ corneal transplant (left eye ___, right eye ___)
- ☐ intravitreal injections (left eye ___, right eye ___)
- ☐ strabismus surgery (left eye ___, right eye ___)
- ☐ retinal surgery (left eye ___, right eye ___)
- ☐ glaucoma surgery (left eye ___, right eye ___)
- ☐ cataract surgery (left eye ___, right eye ___)

FAMILY HISTORY [please check all that apply]

diabetes	☐ Mother	☐ Father	☐ Siblings	☐ Grandparents
cancer	☐ Mother	☐ Father	☐ Siblings	☐ Grandparents
heart disease	☐ Mother	☐ Father	☐ Siblings	☐ Grandparents
stroke	☐ Mother	☐ Father	☐ Siblings	☐ Grandparents
migraine	☐ Mother	☐ Father	☐ Siblings	☐ Grandparents
hypertension	☐ Mother	☐ Father	☐ Siblings	☐ Grandparents
blindness	☐ Mother	☐ Father	☐ Siblings	☐ Grandparents
glaucoma	☐ Mother	☐ Father	☐ Siblings	☐ Grandparents
cataracts	☐ Mother	☐ Father	☐ Siblings	☐ Grandparents
retinal detachment	☐ Mother	☐ Father	☐ Siblings	☐ Grandparents
strabismus	☐ Mother	☐ Father	☐ Siblings	☐ Grandparents
macular degeneration	☐ Mother	☐ Father	☐ Siblings	☐ Grandparents

☐none ☐other _____

ALERTS

Do you have any of the following?

☐ pacemaker	☐ artificial joints (within 2 yrs)	☐ artificial heart valve
☐ defibrillator	☐ blood thinners	☐ problems with scarring

EMERGENCY CONTACT

_____	_____	_____
Name	Relationship	Telephone

HEALTH CARE PROXY

Do you have a healthcare proxy in the event you are unable to make your own decisions? ☐ Yes ☐ No

If yes, please provide the following:

_____	_____	_____
Name	Relationship	Telephone

MEDICATIONS

Are you currently on any prescription medications? ☐ Yes ☐ No If yes, please list below

If you have a medication list, please include with intake forms.

Name	Dose	Frequency

Do you consent to allow OOC to obtain your medication history from your pharmacy, health plans and other healthcare providers? ☐ Yes ☐ No If yes, please initial _____

Do you take any over-the-counter drugs, vitamins or supplements? ☐ Yes ☐ No If yes, please list below

Name	Dose	Frequency

ALLERGIES

Do you have any allergies? ☐ Yes ☐ No If yes, please specify? _____

SOCIAL HISTORY [please check all that apply]

Cigarette Smoking: ☐ never smoked ☐ quit/former smoker ☐ smokes daily

Alcohol Use: ☐ none ☐ less than 1 drink/day ☐ 1-2 drinks/day ☐ 3 or more drinks/day

PATIENT AUTHORIZATION FORM

Authorization for Release of Protected Health Information (PHI)

General Information

As a patient of Oculoplastic and Orbital Consultants ("OOC"), when you receive medical care (past, present, and future), Protected Health Information (PHI) is obtained to be used for your treatment, obtaining payment from your insurance company and for healthcare operations within OOC. PHI is any information in your medical record that can be used to identify you, and that was created by or disclosed to OOC in the course of providing a health care service, such as a diagnosis or treatment.

Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The Notice is available on our website, in our waiting room and at the reception desk. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

Patient Rights

You have the right to restrict the uses and disclosures of your PHI for the purpose of your treatment, payment for your services and the healthcare operations of OOC. However, we are not required to agree to requested restrictions.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Permission to release Your Protected Health Information to family members or other designated individual(s).

I designate the following representative(s) who the doctor or clinical staff can communicate with on my behalf. If I do not designate anyone, I understand that the doctor or clinical staff will be unable to speak with anyone regarding my medical condition.

_____ _____

Name Relationship

_____ _____

Name Relationship

Your signature below acknowledges:

- You have read and understand this consent.
- You agree to have the PHI used and disclosed by OOC for the purpose of your treatment, to secure payment for your treatment and for OOC healthcare operations.
- Prior to signing this consent, you were given the opportunity to review our "Notice of Privacy Practices."
- You are permitting the release of your PHI to the persons noted above.
- You are aware that you may now or at any time revoke this consent and request restrictions to the use and disclosure of your PHI.
- The Practice may condition receipt of treatment upon the execution of this Consent
- A copy of this notice may be requested in person, by mail, or by phone during normal business hours.

_____ _____ _____

Printed - Patient Name or Personal Representative Date of Birth Date Signed

_____ _____

Signature - Patient Name or Personal Representative Date Signed
(If Representative signs, include legal document and print name below)