

## PATIENT INFORMATION FORM

### PATIENT DATA

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security [last 4 digits]: \_\_\_\_\_  Female  Male

### PREFERRED METHOD OF CONTACT

Home: \_\_\_\_\_ Preferred phone number  Home  Work  Mobile

Cell: \_\_\_\_\_ May we leave a detailed message?  Yes  No

Email: \_\_\_\_\_ May we email medical information  Yes  No  
without encryption (password protected)?

Preferred method of communication?  Text message  Phone  Email

May we email you about upcoming events + exclusive offers?  Yes  No

### 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.

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Signature of Patient

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Date



# PATIENT HEALTH QUESTIONNAIRE

## PATIENT DATA

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

## PAST MEDICAL HISTORY [please check all that apply]

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

- |  |   |
|--|---|
| <input type="checkbox"/> allergic conjunctivitis | <input type="checkbox"/> cataract (left eye ____, right eye ____)             |
| <input type="checkbox"/> blepharitis             | <input type="checkbox"/> corneal dystrophy (left eye ____, right eye ____)    |
| <input type="checkbox"/> dry eyes                | <input type="checkbox"/> diabetic retinopathy (left eye ____, right eye ____) |
| <input type="checkbox"/> ophthalmic migraine     | <input type="checkbox"/> glaucoma (left eye ____, right eye ____)             |
| <input type="checkbox"/> strabismus              | <input type="checkbox"/> macular degeneration (left eye ____, right eye ____) |
| <input type="checkbox"/> none                    | <input type="checkbox"/> narrow angles (left eye ____, right eye ____)        |
| <input type="checkbox"/> other _____             | <input type="checkbox"/> retinal detachment (left eye ____, right eye ____)   |
|  | <input type="checkbox"/> vitreous floaters (left eye ____, right eye ____)    |

## OCULAR SURGERY [please check all that apply]

- |  |  |
|--|--|
| <input type="checkbox"/> blepharoplasty (upper ____, lower ____)       | <input type="checkbox"/> corneal transplant (left eye ____, right eye ____)      |
| <input type="checkbox"/> ptosis repair (left eye ____, right eye ____) | <input type="checkbox"/> intravitreal injections (left eye ____, right eye ____) |
| <input type="checkbox"/> punctal plugs (left eye ____, right eye ____) | <input type="checkbox"/> strabismus surgery (left eye ____, right eye ____)      |
| <input type="checkbox"/> Lasik (left eye ____, right eye ____)         | <input type="checkbox"/> retinal surgery (left eye ____, right eye ____)         |
| <input type="checkbox"/> none  | <input type="checkbox"/> glaucoma surgery (left eye ____, right eye ____)        |
| <input type="checkbox"/> other _____                                   | <input type="checkbox"/> cataract surgery (left eye ____, right eye ____)        |

PATIENT HEALTH QUESTIONNAIRE (cont'd)



**FAMILY HISTORY** [please check all that apply]

- |                               |                                      |                                 |                                   |                                       |
|-------------------------------|--------------------------------------|---------------------------------|-----------------------------------|---------------------------------------|
| diabetes                      | <input type="checkbox"/> Mother      | <input type="checkbox"/> Father | <input type="checkbox"/> Siblings | <input type="checkbox"/> Grandparents |
| cancer                        | <input type="checkbox"/> Mother      | <input type="checkbox"/> Father | <input type="checkbox"/> Siblings | <input type="checkbox"/> Grandparents |
| heart disease                 | <input type="checkbox"/> Mother      | <input type="checkbox"/> Father | <input type="checkbox"/> Siblings | <input type="checkbox"/> Grandparents |
| stroke                        | <input type="checkbox"/> Mother      | <input type="checkbox"/> Father | <input type="checkbox"/> Siblings | <input type="checkbox"/> Grandparents |
| migraine                      | <input type="checkbox"/> Mother      | <input type="checkbox"/> Father | <input type="checkbox"/> Siblings | <input type="checkbox"/> Grandparents |
| hypertension                  | <input type="checkbox"/> Mother      | <input type="checkbox"/> Father | <input type="checkbox"/> Siblings | <input type="checkbox"/> Grandparents |
| blindness                     | <input type="checkbox"/> Mother      | <input type="checkbox"/> Father | <input type="checkbox"/> Siblings | <input type="checkbox"/> Grandparents |
| glaucoma                      | <input type="checkbox"/> Mother      | <input type="checkbox"/> Father | <input type="checkbox"/> Siblings | <input type="checkbox"/> Grandparents |
| cataracts                     | <input type="checkbox"/> Mother      | <input type="checkbox"/> Father | <input type="checkbox"/> Siblings | <input type="checkbox"/> Grandparents |
| retinal detachment            | <input type="checkbox"/> Mother      | <input type="checkbox"/> Father | <input type="checkbox"/> Siblings | <input type="checkbox"/> Grandparents |
| strabismus                    | <input type="checkbox"/> Mother      | <input type="checkbox"/> Father | <input type="checkbox"/> Siblings | <input type="checkbox"/> Grandparents |
| macular degeneration          | <input type="checkbox"/> Mother      | <input type="checkbox"/> Father | <input type="checkbox"/> Siblings | <input type="checkbox"/> Grandparents |
| <input type="checkbox"/> none | <input type="checkbox"/> other _____ |                                 |                                   |                                       |

**ALERTS**

Do you have any of the following?

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> pacemaker     | <input type="checkbox"/> artificial joints (within 2 yrs) | <input type="checkbox"/> artificial heart valve |
| <input type="checkbox"/> defibrillator | <input type="checkbox"/> blood thinners                   | <input type="checkbox"/> 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, what? \_\_\_\_\_

**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  
(If Representative signs, include legal document and print name below)

\_\_\_\_\_  
Date Signed