THE MEDICAL EYE CENTER

PATIENT INFORMATION

Private and Confidential
Without Prejudice - Not for Publication

(Please Print)

Last Name _____ First Name _____ MI _____

Date of Birth (MM/DD/YY)_____ Age: _____

Address _____
Street City State Zip

Home Phone _____Work Phone _____Cell Phone_____

Best Phone Number to Use to Contact You? _____

Email address:_____

Occupation _____ Employer _____

Who to notify in emergency (nearest relative or friend)?
Name _____ Relationship _____
Home Phone _____ Work Phone _____

INSURANCE INFORMATION (Please give the insurance card to the receptionist)
Primary Insurance – Name of Insured: _____ DOB: _____
SSN: _____ Relationship to Patient: _____
Employer Name: _____
Secondary Insurance – Name of Insured: _____ DOB: _____
SSN: _____ Relationship to Patient: _____
Employer Name: _____

Complete if under 18 years or a student:
Name of Parent or Guardian Responsible for Payment:_____

NOTICE: A **refraction** is a measurement of the lens power necessary to prescribe glasses or other corrective lenses. **Most medical insurance plans**, **do not cover routine refractions or routine eye examinations**. There is a separate charge for that portion of the examination, since it is not a covered service. **THE MINIMUM CHARGE FOR A ROUTINE REFRACTION IS $35.00.**

FINANCIAL ASSIGNMENT AND AGREEMENT:

1. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. **In order to control our cost of billing, it is your responsibility to pay any deductible amount, co-pay, or any other balance not paid for by your insurance at the beginning of each office visit.**
2. I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished me. I authorize any holder of medical information about me released to the Health Care Financing Administration, its agents, or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services.
3. Requests for medical records require a minimum of one week to process, and a $10.00 processing fee.
4. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

SIGNED ✕_____ Date _____
PERSON RESPONSIBLE FOR PAYMENT

MEDICAL HISTORY

(Please Print)

Patient's Name: _____ Age: _____ Sex: _____

Primary Care Physician (PCP): _____ Were you referred by your PCP? Yes No

DO YOU GIVE PERMISSION FOR DR. SINGH TO DO A COMPLETE MEDICINE RECONCILLIATION? YES / NO
(This is done for your protection in regard to possible drug interaction.)

1. Are you **currently** experiencing any eye symptoms? (Yes / No) If yes, please circle all that apply:

Eye Pain	Blurred Vision	Eyelid Crusting	Flashes of Light
Halos	Red Eyes	Light Sensitivity	Double Vision
Floaters	Discharge	Eye Pressure	Foreign Body Sensation

2. Please circle any of the following you would like more information about:

Cataract Surgery	Macular Degeneration	Diabetic Eye Disease
Glaucoma	Laser Vision Correction	Other: _____

3. Please answer the following questions about your medical status and history:
   1. Have you ever been treated for any medical conditions (e.g., diabetes, high blood pressure, arthritis, etc)
      Yes ◇ No ◇ If YES, please explain: _____
   2. Have you ever had any eye disease (e.g., glaucoma, cataract, wandering or "lazy" eye, retinal detachment, eye injury)
      Yes ◇ No ◇ If YES, please explain: _____
   3. Have you ever had any eye surgery?
      Yes ◇ No ◇ If YES, please explain: _____
   4. Have you ever been hospitalized?
      Yes ◇ No ◇ If YES, please explain: _____
   5. Do you take medications?
      Yes ◇ No ◇ If YES, please explain: _____
   6. Do you take/use any eye medications:
      Yes ◇ No ◇ If YES, please explain: _____
   7. Do you have any drug or food allergies?
      Yes ◇ No ◇ If YES, please explain: _____

REVIEW OF SYSTEMS

Do you **currently** have any of the following problems:	Yes	No	If Yes, please explain
Chronic fever, unexpected weight loss/gain, fatigue	◇	◇	_____
Ear/nose/throat problems (e.g., hearing loss, sinus problems)	◇	◇	_____
Heart problems (e.g., chest pain, irregular heart beat)	◇	◇	_____
Respiratory problems (e.g., shortness of breath, wheezing, coughing)	◇	◇	_____
Gastrointestinal problems (e.g., heartburn, abdominal pain, diarrhea)	◇	◇	_____
Urinary problems (e.g., pain discomfort, blood in urine)	◇	◇	_____
Skin problems (e.g., rashes, excessive dryness)	◇	◇	_____
Musculloskeletal problems (e.g., muscle aches, joint pain)	◇	◇	_____
Neurological problems (e.g., numbness, weakness, headaches)	◇	◇	_____
Psychiatric problems (e.g., depression, anxiety)	◇	◇	_____

FAMILY AND SOCIAL HISTORY

Do any medical or eye diseases run in your family (e.g., diabetes, high blood pressure, cancer, glaucoma, macular degeneration)
◇ Yes ◇ No If Yes, please explain _____

Do you smoke? ◇ Yes ◇ No If Yes, how much? _____ Drink alcohol? ◇ Yes ◇ No If Yes, how much? _____

_____

Consent to Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations and Acknowledgement of Receipt of Notice of Privacy Practices

I understand that as part of my healthcare, Gagan J. Singh, M.D., originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

1. A basis for planning my care and treatment;
2. A means of communication among the many health professionals who contribute to my care;
3. A source of information for applying my diagnosis and surgical information to my bill; and
4. A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided the opportunity to view the Notice of Privacy practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the Practice reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address that I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to see and obtain copies of my medical record, I understand that I have the right to request amendments to be made to my medical record. I understand that a six-year history of all disclosures will be accessible to me including the purpose of the disclosure and the address of the recipient. I may receive a copy of this history within 60 days of written request, and I understand that I may have to pay a reasonable charge of $0.20 per page for any copies after the first request in a 12 month period. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the Practice as already taken action in reliance thereon.

IF YOU HAVE RESTRICTIONS, PLEASE NOTE THEM BELOW. IF NO RESTRICTIONS, PLEASE WRITE NONE.

✦ I request the following restrictions be made to the use or disclosure of my health information:

_____

✦ I request restrictions be made to the use or disclosure of my health information to certain people:

_____

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE **Date**

x _____ _____