MARYLANDVISION CENTER

Name: ______________________________________________ Birth Date: _____/_____/_____

Optometrist: __________________________ Family Doctor/Internist: _________________________

Pharmacy (Name & Location): ________________________________________________________

**What is the main ocular reason for your visit today? (Please describe below including which eye):**

__________________________________ Referred by: _________________________________

**SYSTEMIC ILLNESSES:** (Please mark yes to which applies) ☐ NONE

| YES | | Elaborate: (When were you diagnosed?) | YES | | Elaborate: (When were you diagnosed?) |
|---|---|---|---|---|---|
| | AIDS/HIV | | | Bleeding Problems | |
| | Cancer (List what kind) | | | Digestive Problems | |
| | Congestive Heart Failure | | | Heart Disease/Problems | |
| | Diabetes (What type?) | A1C: | | Immune System Problems | |
| | High Blood Pressure | | | Muscle/Joint Problems | |
| | High Cholesterol | | | Neurological Problems | |
| | Liver Disease | | | Psychiatric Problems | |
| | Rheumatoid Arthritis | | | Pulmonary/Breathing Problems | |
| | Stroke | | | Skin Problems | |
| | Thyroid Disease | | | Other: | |
| | Past Infections (Please list) | | | | |

**GENERAL SURGERIES/OPERATIONS: (Please List with Dates)** ☐ NONE

______________________________________________________________________

______________________________________________________________________

**PAST OCULAR HISTORY:** (Please mark yes to which applies) ☐ NONE

| YES | | RIGHT EYE (X) | LEFT EYE (X): | |
|---|---|---|---|---|
| | Amblyopia | | | Do you currently wear glasses? ☐ Yes For ☐ Distance ☐ Reading |
| | Cataract Surgery or Cataracts (Please Circle which applies) | | | |
| | Diabetic Retinopathy | | | |
| | Glaucoma | | | |
| | Iritis/Uveitis | | | |
| | Keratoconus | | | |
| | Macular Degeneration | | | |
| | Retinal Detachment or Tear | | | Do you currently wear contact lenses? ☐ Yes What type? ____________ |
| | History of Eye Injury | | | |
| | Optic Neuritis | | | |
| | Hyperopia (Far Sighted), Myopia (Near Sighted), Lazy Eye (Circle which applies) | | | |
| | Other Eye Surgery | | | |

**EYE SYMPTOMS:** (Please mark yes to which applies) ☐ NONE

| YES (X) | | RIGHT EYE/DATE | LEFT EYE/DATE |
|---|---|---|---|
| | Blurry Distance Vision | | |
| | Blurry Near Vision | | |
| | Distortion, Loss, or Fluctuating Vision | | |
| | Double Vision | | |
| | Glare, halos around lights | | |
| | Eye Tearing | | |
| | Itching/Burning of Eyes | | |
| | Growth on Eyelids | | |
| | Eye Pain/Soreness or Foreign Body Sensation | | |
| | Floaters | | |
| | Flashes of Light | | |
| | Redness | | |
| | Light Sensitivity | | |
| | Other Symptoms: | | |

**CURRENT MEDICATIONS** (Please list below): ☐ NONE

| **SYSTEMIC MEDICATIONS:** | | **EYE MEDICATIONS:** | |
|---|---|---|---|
| NAME: | HOW OFTEN: | NAME: | HOW OFTEN: |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**ALLERGIES** (Please list or check box): ☐ NO KNOWN DRUG ALLERGIES

______________________________________________

______________________________________________

**FAMILY HISTORY:**

| YES (X) | | Which family member? |
|---|---|---|
| | Diabetes | |
| | Blindness | |
| | Glaucoma | |
| | Macular Degeneration | |
| | Cancer | |
| | Lazy Eye | |

**SOCIAL HISTORY:**

| | YES (X) | NO (X) | HOW OFTEN? |
|---|---|---|---|
| Alcohol? | | | |
| Smoke? ☐ Former Smoker | | | |

I certify that I have examined the above information and that it is true, accurate and complete to the best of my knowledge.

Signature: ______________________________ Date: ______/_______/_______

MARYLANDVISION
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## PATIENT INFORMATION

Patient's Name: ____________________________Sex (Circle One): Male Female DOB:____/____/_____

Social Security No.: ____________________ Marital Status (Circle One): Single Married Widows Divorced

Home Phone #: ___________________ Cell Phone #: _________________ Work #: ________________

Preferred Contact: □ Cell Phone □ Home □ Other __________________________________________

Street Address: _________________________________________________________________________

City: _____________________________________ State:________________ Zip Code:_____________

Email (**Required**): _______________________________________________________________________

Who is the Financially Responsible Party/Primary Insurance Holder? □ Self □ Other (Please list below)

Name: _____________________________________________ Relationship: ______________________

Address: ______________________________________________________________________________

**Insurance Information**:

**Primary Insurance**: ____________________________________________________________________

Insured Name: _________________________________ Phone #: _______________________________

Relation: __________________________________________________ DOB: ______/_______/_______

Insured Employer: ________________________________ Insured SSN: _________________________

Group/Policy #: __________________________________ Co-Pay $: ____________________________

**Secondary Insurance**:____________________________________________________________________

Insured Name: _________________________________ Phone #: _______________________________

Relation: __________________________________________________ DOB: ______/_______/_______

Insured Employer: ________________________________ Insured SSN: _________________________

Group/Policy #: __________________________________ Co-Pay $: ____________________________

I request the insurance carrier or Medicare to pay directly to Maryland Vision Center, PA the amount due for any services rendered. I also agree to pay any amount that the insurance carrier or Medicare deems as not a covered benefit and also any amount the insurance carrier or Medicare determines to be my responsibility. I understand that an EYE Exam includes medical examination of my eyes and often a refraction, which may lead to a glasses prescription. It does not include contact lens fitting, corneal measurements or contact lens specifications. In all cases, professional fees are the responsibility of the patient and/or the stated financially responsible party. I agree to treatment deemed necessary by the physician and authorize the release of any medical information required by the involved parties to be necessary to process this claim. Patient or financially responsible party(ies) further agree to pay any and all collection fees incurred and legal expenses, including but not limited to Collection Agency and Attorney fees, court expenses, service and filing fees.

Signature: _________________________________________________ Date: ______/_______/______

MARYLANDVISION
C E N T E R

## HIPAA Authorization Release Form

Name: ____________________________________________ Date of Birth: _____ / _____ / ______

Release of Information

☐I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be release to:

☐Spouse: ____________________________________________________

☐Child(ren): ____________________________________________

☐Other: ______________________________________________________

☐Information is NOT to be release to anyone

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call: ☐my home ☐my work ☐my cell phone

If unable to reach me:

☐You may leave a detailed message

☐Please leave a message asking me to return your call

☐Other: _______________________________________________

The best time to reach me is: (day) _________________ between (time) _________________

Signed: __________________________________________ Date: _____ / _____ / ______

Witness: _________________________________________ Date: _____ / _____ / _____

# Please initial by each statement.

ACKNOWLEDGMENT: RECEIPT OF NOTICE OF PRIVACY PRACTICES

_____I have read/received a copy of Maryland Vision Center's Notice of Privacy Practices effective 10/25/2013.

**OR**

_____I am a parent or legal guardian of ______________________ (patient name). I have read/received a copy of Maryland Vision Center's Notice of Privacy Practices effective 10/25/2013.

CANCELLATION POLICY

_____We understand that there are emergencies and obligations that may cause you to miss a scheduled appointment. If you are not able to make an appointment, we require that you notify us at least 24 hours in advance. If you reschedule, no-show, or cancel 3 consecutive appointments without proper notification you may be discharged from our care.

I understand and agree to all the statements I have initialed above.

Printed Name: __________________________________

Signature: _____________________________________

Date: ________________________________________

MARYLANDVISION
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# PATIENT FINANCIAL RESPONSIBILITY

Patient Financial Responsibilities

- The patient is ultimately responsible for the payment of his/her treatment and care.
- We will submit the claim to the insurance companies. However, the patient is required to provide us with the most current and correct information regarding their insurance.
- Patients are responsible for copays, coinsurance, deductibles, and all other procedures/treatment not covered by their insurance plans.
- Patients, who require a referral, are responsible for obtaining the referral from their PCP before their visit. If the patient does not have the referral, we will make all attempts to obtain a referral. If we cannot obtain a referral, the patient will be responsible for the balance due.
- Payment is due at time of service. We accept cash, check, Visa, MasterCard, American Express, Discover and Care Credit.
- Patients may incur and are responsible for payment of additional charges for the following:
- Returned check charge--$25
- Missed appointments--$25
- Extensive forms completion--$25
- Please be aware that if you are unable to pay our office the amount due at the time of service, you may be asked to reschedule your appointment or you may choose to sign a financial payment agreement.
- If you are unable to pay your balance, YOU WILL BE RESPONSIBLE FOR THE CHARGES ASSOCIATED WITH SENDING YOU TO COLLECTIONS. THIS COULD INCLUDE A CHARGE OF 25% - 35% IN ADDITION TO THE BALANCE YOU OWE OUR PRACTICE.

Patient Authorizations

- I hereby authorize assignment of financial benefits directly to MDVC and any associated healthcare entities for services rendered as allowable under standard third-party contracts. I understand that I am financially responsible for charges not covered by assignment.
- I authorize MDVC personnel to communication by mail, answering machine message, and/or email according to the information I have provided in my patient registration information.

**By signing the bottom of page 1 of New Patient packet, you have agreed to this Patient Financial Responsibility form.**