GROCHMAL EYE CENTER • 405 Frederick Rd. Ste. 102 Catonsville MD 21228 • 410-744-5310

Patient Information

NAME: _____ **GENDER:** Male Female

ADDRESS: _____ **DATE OF BIRTH:** _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

PHONE NUMBERS: Home_____ **Cell**_____ **Work**_____

RACE: _____ **ETHNICITY: Hispanic**_____ **Not Hispanic**____ **Decline to Answer**____

MARITAL STATUS: Married Divorced Single Widowed Other

EMAIL ADRESS: _____

OCCUPATION: _____

Name of Employer: _____

PARENT/LEGAL GUARDIAN (if minor child): _____

PRIMARY INSURANCE:

PLAN: _____

SUBSCRIBER ID: _____

GROUP#: _____

SUBSCRIBER'S NAME: _____

BIRTHDATE: _____

SECONDARY INSURANCE:

PLAN: _____

SUBSCRIBER ID: _____

GROUP#: _____

SUBSCRIBER'S NAME: _____

BIRTHDATE: _____

I consent to treatment necessary for the care of the above-named patient. I authorize the release of all medical records to the referring and family physicians to my insurance company, if applicable. I will allow fax transmittal of my medical records if necessary. I acknowledge full financial responsibility for services rendered to **Grochmal Eye Center** and authorize transfer of all unpaid amounts to my Visa/MC or other credit card by phone 120 days from the date of service unless other definite financial arrangements have been made prior to treatment. I agree to pay all reasonable attorney fess and collection costs in the event of a default of payment of my account. I further authorize and request that all insurance payments be made to **Jay C. Grochmal M.D. P.A.**

I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.

SIGNATIRE: _____ DATE: _____

PATIENT HISTORY **Date (office use only):** _____

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

Employer: _____ **Occupation:** _____

Primary Care Physician: _____ **PCP Phone Number:** _____

Pharmacy (Location, phone number): _____

Referred by: □ **Doctor:** _____ □ **Friend:** _____

□ **Website** □ **Print Ad** □ **Other:** _____

MEDICAL HISTORY: Please fill out **FRONT AND BACK** to the best of your knowledge.

CURRENT/PAST EYE CONDITIONS (If yes, please give details below):

Cataracts □ No □ Yes _____ Retinal Detachment □ No □ Yes _____

Macular Degeneration □ No □ Yes _____ Glaucoma □ No □ Yes _____

Other □ No □ Yes _____

CURRENT/ PAST MEDICAL CONDITIONS (Please provide as much detail as possible):

Diabetes □ No □ Yes _____ Thyroid Problem □ No □ Yes _____

Arthritis □ No □ Yes _____ Hypertension □ No □ Yes _____

Asthma □ No □ Yes _____ Heart Problem □ No □ Yes _____

Other □ No □ Yes _____

SOCIAL HISTORY: Do you…

Drink Alcohol? □ No □ Social □Daily □ 3+ Drinks/Day

Smoke? □ Never □ Former, Quit _____ □Current, Details (How much/ how often?) _____

Use drugs? □ No □ Yes, Details (How much?/ How often?/Type?) _____

FAMILY HISTORY: Does anyone in your family have a history of…

Glaucoma? □ No □ Yes Relationship to Patient: _____

Macular Degeneration? □ No □ Yes Relationship to Patient: _____

Retinal Detachment? □ No □ Yes Relationship to Patient: _____

Diabetes? □ No □ Yes Relationship to Patient: _____

Any other medical conditions? □ No □ Yes, Specify Condition and Relationship to Patient: _____

_____

********** PLEASE FILL OUT OTHER SIDE**********

SURGICAL HISTORY:

Please include relevant details to the best of your ability- dates, locations, surgeons, etc.

OCULAR SURGERIES	
Date	Procedure (Please specify eye)

MEDICAL SURGERIES	
Date	Procedure

HAVE YOU HAD ANY PROBLEMS WITH ANESTHESIA? ☐ No ☐ Yes, Explain _____

REVIEW OF SYSTEMS:

Do you have any problems with the following?:		Specify Condition
Constitution (ex. fever, weight gain/loss, fatigue, etc.)	☐ No ☐ Yes	
Heart (ex. chest pain, irregular heartbeat, etc)	☐ No ☐ Yes	
Ear/Nose/Throat (ex. hearing loss, sinus infection, etc)	☐ No ☐ Yes	
Respiratory (ex. Shortness of breath, asthma, wheezing, cough, etc)	☐ No ☐ Yes	
Gastrointestinal (ex. Heartburn, abdominal pain, diarrhea, etc)	☐ No ☐ Yes	
Urinary (ex. pain, discomfort, blood in urine, etc)	☐ No ☐ Yes	
Musculoskeletal (ex. muscle aches, joint pain, swollen joints, etc)	☐ No ☐ Yes	
Skin (ex. Excessive dryness, rashes, etc)	☐ No ☐ Yes	
Neurologic (ex. Seizures, numbness, weakness, paralysis, headaches, etc.)	☐ No ☐ Yes	
Psychiatric (ex. Depression, anxiety, etc.)	☐ No ☐ Yes	

Signature of Patient: _____ **Date:** _____

Signature of Physician: _____ **Date:** _____

Name: _____

PATIENT MEDICATION LIST

Date (office use only): _____

Do you take any **PRESCRIPTION MEDICATIONS?** ☐ No ☐ Yes
If yes, please specify in as much detail as possible.

Name and Dosage (Strength)	Name and Dosage (Strength)

Do you take any **OVER THE COUNTER MEDICATIONS OR SUPPLEMENTS?** ☐ No ☐ Yes
If yes, please specify in as much detail as possible.

Name and Dosage (Strength)	Name and Dosage (Strength)

Do you have any **ALLERGIES** to:

Medications? ☐ No ☐ Yes _____

Iodine/Shellfish? ☐ No ☐ Yes _____ Fluorescein Dye? ☐ No ☐ Yes _____

Other (Food/Environmental)? ☐ No ☐ Yes _____

SIGNATURE OF PHYSICIAN: _____

DATE: _____

GROCHMAL EYE CENTER

PATIENT CONSENT & WAIVER FORM

I, _____, understand that I am or will be responsible for all charges associated with today's visit and any subsequent visits relating to the diagnosis, testing and treatment of any and all eye conditions, including but not limited to the following items:

- **REFRACTION:** An eye refraction is the test used to determine your prescription for glasses. This service is not covered by MEDICAL INSURANCE. The fee for this service is $35.00 and is due at the time of service.

- **NO REFERRAL AT TIME OF VISIT:** If you did not bring or have a valid referral at the time of your visit but still wish to be seen, you will be responsible for all charges- PAYABLE PRIOR TO THE EXAM.

- **NO INSURANCE:** You will be responsible for all charges associated with all visits- PAYABLE PRIOR TO THE EXAM.

- **WORKMEN'S COMPENSATION CLAIMS:** If provided with the proper billing information for your Workmen's Compensation claim, we will bill your employer and/or the insurance carrier for your visit(s). We will do this only ONCE. If payment is not received in a timely manner or the claim is denied, you will be responsible for all charges.

- **MISSED APPOITNEMENTS:** Appointments are confirmed prior to your appointment date. If an appointment is cancelled up to 24 hours prior, you will not be charged. If you fail to show for your confirmed appointment, you will be charged $25.00. If multiple family members have appointments on the same day, each person who fails to show will be charged $25.00.

- **INSURANCE POLICIES:** All co-pays and fees are due in full at the time of service and are to be paid PRIOR TO RECEIVING ANY SERVICES.

- **DELIQUENT ACCOUNTS:** In the event that your account becomes delinquent, you will be liable for all reasonable collection/attorney fees plus filing cost and processing fees.

Patient or Responsible Party's Signature: _____

Date: _____

SUMMARY OF PRIVACY PRACTICIES

The following is a brief summary of our Notice of Privacy Practices. The entire text detailing our privacy practices is attached for your review. We encourage you to read the detailed version and ask any questions you may have regarding our privacy practices. After reading the attached version, please fill out the form at the bottom of this acknowledging that you have read and understand our privacy practices. We are required by law to provide you with this notice.

If you have any questions or would like to exercise any of your rights regarding your Private Health Information, please contact our office at 410-744-5310.

PATIENT RIGHTS

As a patient, you have a right to inspect, copy, amend, request a restriction, or revoke a prior restriction on the use and disclosure of your Private Health Information. You may also request a copy of an accounting disclosures which detail all disclosures made for reasons other than treatment, payment, or health care operations. You may request that we communicate with you only in a specific manner such as, "Only communicate with me via my work telephone number."

PROVIDER RIGHTS

As your provider, we can use or disclose your Private Health Information for treatment, payment, or health care operational purposes. Any other disclosure requires you to sign a specific authorization.

ACKNOWLEDGMENT

PATIENT/GUARRDIAN SIGNATURE: _____ **DATE:** _____

PRINT NAME: _____ **DATE OF BIRTH:** _____