MARYLANDVISION
CENTER
MEDICAL & SURGICAL EYE CARE

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PATIENT REGISTRATION INFORMATION-(PLEASE PRINT)

Name: _____
(First) **(Middle)** **(Last)**

Birth Date ____/____/____Social Security Number_____/_____/_____ Gender: Male or Female **(Circle)**

Address: _____ Apartment#_____

City: _____ State: _____ Zip: _____

Home Phone#:_____Cell Phone#:_____Work Phone#:_____

Preferred Contact: __ Home # __Cell # __ Work# **(Please Check)**

Email Address: _____ **(Required)**

Emergency Contact:_____ Phone#: _____

Emergency Contact relationship: _____

Marital Status: Single Divorced Married Widowed Separated **(Circle)**

Primary Care Physician:_____ Phone#: _____

Referred by: _____

Race: American Indian or Alaska Native Asian Black or African American White

Native Hawaiian or Other Pacific Islander Hispanic or Latino

Ethnicity: _ Not Hispanic Hispanic or Latino Preferred language: English Spanish

Primary Insurance Information:

Insurance Company:_____

Policy#_____Group#_____ Co-Pay$_____

Subscribers Name: _____Relationship: _____DOB__/___/___

Secondary Insurance Information:

Insurance Company_____

Policy#_____Group#_____ Co-Pay$_____

Subscribers Name: _____Relationship: _____DOB__/___/___

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PATIENT MEDICAL HISTORY FORM

Name:_____ D.O.B:____/_____/_____
(First) (Middle) (Last)

Primary Care Physician: _____ Referred By: _____

Why were you referred to our practice? _____

➢ **ALLERGIES:** ☐ **No Known Drug Allergies** ☐ **LATEX** ☐ **Erythromycin**

_____ Reaction: _____ mild/ moderate/ severe

_____ Reaction: _____ mild/ moderate/ severe

_____ Reaction: _____ mild/ moderate/ severe

➢ **DO YOU HAVE ANY OF THESE EYE SYMPTOMS?** *(Please mark all that apply)* ☐ **Overall Healthy**

□ Blurry distance vision	□ Eye mattering or tearing	□ Eye pain	□ Flashing lights
□ Blurry near vision	□ Itching or burning eyes	□ Dry Eyes	□ Foreign body sensation
□ Constant double vision	□ Growth on eyelids	□ Redness	□ Floaters
□ Glare, halos around lights	Other_____		

➢ **PAST OCULAR HISTORY** : *(Please mark all that apply)* ☐ **Overall Healthy**

□ Serious eye/head trauma	□ Cataracts	□ Hyperopia (Far sighted)	□ Lazy Eye
□ Macular Degeneration	□ Glaucoma	□ Myopia (Near sighted)	□ Astigmatism
□ Diabetic Retinopathy	□ Keratoconus	□ Amblyopia (Lazy eye)	□ Optic Neuritis
□ Retinal Detachment	□ Dry Eyes	□ Iritis/uveitis	

Other_____

Do you wear: ☐ Glasses ☐ Contacts **For:** ☐ Distance ☐ Reading
If Contacts: ☐ Dailies ☐ Extended Wear ☐ Gas Permeable **Years of usage:** _____

➢ **PLEASE LIST ANY *EYE* SURGERY YOU HAVE HAD**: (Including dates) ☐ **NONE**

_____

_____

➢ **CURRENT *EYE* MEDICATIONS:** ☐ **NONE** ☐ **OTC Artificial Eye Drops**

_____ 1 2 3 4 5 at bedtime

_____ 1 2 3 4 5 at bedtime

_____ 1 2 3 4 5 at bedtime

➢ **CURRENT GENERAL Rx & OTC MEDICATIONS:** (Please list Name /Dosage) ☐ **NONE**

_____

_____

_____

_____

➢ **SYSTEMIC ILLNESSES:** *(Please mark all that apply)* ☐ **Overall Healthy**

☐ Diabetes Type: _____	☐ Anemia	☐ Eczema	☐ Thyroid Disease	☐ Sjogrens
☐ Rheumatoid Arthritis	☐ Arthritis	☐ High Cholesterol	☐ Stroke	☐ Bleeding Disorder
☐ HIV Positive/AIDS	☐ Arrhythmia	☐ Fibromyalgia	☐ Liver Disease	☐ Polymyalgia
☐ Hypothyroidism	☐ Asthma	☐ Kidney Disease	☐ Graves ' Disease	☐ Multiple Sclerosis
☐ Hyperthyroidism	☐ COPD	☐ Psychiatric Disorder	☐ Hearing Loss	☐ Lung Disease
☐ High Blood Pressure	☐ Migraine	☐ Headache	☐ Arrhythmia	☐ Kidney Stones
☐ Lupus	☐ Congestive Heart Failure			

☐ Cancer Type: _____ Other_____

➢ **GENERAL SURGERIES/OPERATIONS:** (Please list) ☐ **NONE**

_____

_____

➢ **FAMILY HISTORY:** (Please mark all that apply) ☐ **NONE**

☐ Diabetes	☐ Kidney Disease	☐ Macular Degeneration	☐ Cataracts	☐ Cancer	☐ Stroke
☐ Blindness	☐ Retinal Disease	☐ High Blood Pressure	☐ TB	☐ Arthritis	☐ Lazy Eye
☐ Glaucoma	☐ Heart Disease				

Other:_____

➢ **HISTORY OF INFECTIONS:** (Please mark all that apply) ☐ **NONE**

☐ Herpes Simplex	☐ HIV / AIDS	☐ Syphilis	☐ Wound Infection
☐ Chicken Pox	☐ Herpes Zoster / Shingles	☐ Meningitis	☐ Toxoplasmosis
☐ Hepatitis A / B / C	☐ Histoplasmosis	☐ MRSA	☐ Chlamydia

➢ **SOCIAL HISTORY**: (Please mark all that apply)

Alcohol Use: ☐ Yes ☐ No **If yes how much and how often?** _____

Smoking: ☐ current every day smoker ☐ current some day smoker ☐ former smoker ☐ never smoked

Drug Use: ☐ Yes ☐ No **If yes what and how often?** _____

➢ **REVIEW OF SYSTEMS (ROS)**: (Please mark all that apply)

GENERAL- □ Weight loss or gain □ Fatigue □ Fever or chills □ Weakness □ Trouble sleeping

SKIN- □ Rashes □ Lumps □ Itching □ Dryness □ Color changes □ Hair and nail changes

HEAD- □ Headache □ Head injury □ Neck Pain

EARS- □ Decreased hearing □ Ringing in ears □ Earache □ Drainage

NOSE- □ Stuffiness □ Discharge □ Itching □ Hay fever □ Nosebleeds □ Sinus pain

THROAT- □ Bleeding □ Dentures □ Sore tongue □ Dry mouth □ Sore throat □ Hoarseness □ Thrush □ Non-healing sores

NECK- □ Lumps □ swollen glands □ Pain □ Stiffness

BREAST- □ Lumps □ Pain □ Discharge □ Self-exams □ Breast-feeding

RESPIRATORY- □ Cough □ Sputum □ Coughing up blood □ Shortness of breath □ Wheezing □ Painful breathing

CARDIOVASCULAR- □ Chest pain or discomfort □ Difficulty breathing lying down □ Tightness □ Palpitations □ Swelling □ Shortness of breath with activity □ Sudden awakening from sleep with shortness of breath

GASTROINTESTINAL- □ Swallowing difficulties □ Heartburn □ Change in bowel habits □ Nausea □ Leg cramping □ Rectal bleeding □ Constipation □ Diarrhea □Yellow eyes or skin □ Change in appetite

URINARY- □ Frequency □ Urgency □ Burning or pain □ Blood in urine □ Incontinence □ Change in urinary strength

VASCULAR- □ Calf pain with walking

MUSCULOSKELETAL- □ Muscle or joint pain □ Stiffness □ Back pain □ Redness of joints □ Swelling of joints □ Trauma

NEUROLOGIC- □ Dizziness □ Fainting □ Seizures □ Weakness □ Numbness □ Tingling □ Tremor

HEMATOLOGIC- □ Ease of bruising □ Ease of bleeding

ENDOCRINE- □ Head or cold intolerance □ Sweating □ Frequent urination □ Thirst □ Change in appetite

PSYCHIATRIC- □ Nervousness □ Stress □ Depression □ Memory loss.

Signature of Patient _____ *Date:* _____

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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.

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) _____

Emergency Contact: Name: _____

Relationship: _____ Contact Number: (____) _____ _____

X Signed: _____ Date: ___ / ___ / ____

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Financial Policy

Please read the following agreement and then sign and date this form to show that you have read and understand this policy. It explains your financial obligations while under our care and our office policies.

CANCELLATION

We realize that situation may arise that could force you to postpone your visit. Please understand that such changes affect not only our Physicians and our staff, but other patients as well.

If you cancel your appointment with less than 24 hours' notice,or fail to show for your testing appointment without notification, you will be charged a service fee up to, but not to exceed, $50 for any missed Office Visit.

If you cancel your surgery with less than 48 hours' notice, or fail to show for your surgery without notification, you will be charged a service fee up to, but not exceed, $200 for any missed surgery appointment.

RETURNED CHECKS

Any checks returned from your bank unpaid, will be assessed a fee of $35.00. After a returned check is received, we will no longer accept checks from you.

INSURANCE INFORMATION

We bill most insurance carriers for you, if proper paperwork is provided for us. Co-payments are due at the time of service. This arrangement is part of your contract with your insurance company. **It is your responsibility to know what your benefits are through your insurance carrier.**

COVERAGE CHANGES

If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

SELF PAY

Self-pay patients must make a payment in full at the time of service.

New Patient Office Visit $165

Established Patient Office Visit $120

Visual Testing $60

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REFERRALS

Your insurance company may need you to supply certain information directly. It is your responsibility to obtain any referrals required by your health insurance and failure to do so will result in nonpayment by the insurer leaving your responsible for the entire balance.

COLLECTIONS

Payment is due at time of service. Aging on accounts begins as of the date of service. Billing arrangements must be approved by the billing staff.

After 120 days any unpaid account may be referred to collections and a $10 billing fee will be assessed.

Collections will have two phases. Initial phase will consist of letter/phone contact. Patient's balances will not be written off. Patients may also be assessed a collections fee which is based on the amount that is unpaid by the patient. Phase Two begins after 90 days if no payments are being made on the account. The patient will be responsible for all collection fees, court costs, and attorney fees. These accounts will be considered in default. The patient will be discharged and not allowed to return to the practice.

Patients with a balance, who provide us an incorrect address and/or invalid telephone number, may be referred to Phase 2 collections without notice. Also those patients who do not provide us with a change of address/phone number within 30 days of the change may also be referred to collections without notice.

MEDICARE PATIENTS

Please read and sign below. I request payment of authorized Medicare benefits be made either to me or my behalf to Maryland Vision Center for any services furnished me by the listed facility. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine those benefits or the benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA 1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the provider agrees to accept the charge determined of the Medicare carrier as the full charge and the patient is responsible only for the coinsurance, deductible and non-covered services. Co-insurances and the deductible are based upon the charge determination of the Medicare carrier.

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ASSIGNMENT OF INSURANCE BENEFITS

Patients with insurance please read and sign below. I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans, to Maryland Vision Center. 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 to release all information necessary to secure the payment.

MEDICAL RECORDS

There is a .50 fee after 5 pages that the patient will be charged for their records for being copied and medical records release form must be signed first.

Any form completion needed to be filled out by the physician must schedule an appointment with the physician.

I have read, understand and agree to the financial policy. I hereby authorize the release of any pertinent information to your insurance company and any other doctors involved in my case. If my account becomes assigned to a collection agency, I agree to pay all collection fees, court costs, and attorney fees. I also authorize agents to communicate via cell phone to address any issues related to service and/or in facilitating payment. I/the patient understand this is authorizing and/or their agents to communicate by means of an automated computerized dialer, and I understand that this form of communication may incur an expense per minute. I understand that ultimately the patient is responsible for all facility fees. I also understand that this agreement can be changed by Maryland Vision Center without further notice to the patient.

Patient's name (PLEASE PRINT)

Signature of Patient and/or Guardian (SEAL)