Swaraj Bose, MD
NeuroEyeOrbit Institute
8631 W. 3rd St, 200E
Los Angeles, CA 90048

Patient Demographic and Insurance Intake Form

Last Name: _____ First name: _____ MI: _____

DOB: _____ SS #: _____ Sex: _____ Marital Status _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

E-mail: _____@_____ Referred by: _____

Primary Care Physician Name and Phone: _____

Pharmacy Name and Phone No.: _____

Insurance Information

Primary Insurance Co: _____ ID #: _____ Grp #: _____

Secondary Ins Co: _____ ID #: _____ Grp #: _____

Policy Holder name: _____ ID #: _____

Policyholder DOB: _____ Policy holder address: _____

Policyholder SS #: _____ Policyholder Sex: _____ Copay Amount: _____

Patient Authorization

I authorize the release of any medical information necessary to process any claim. I authorize payment of medical benefits to the physician for services rendered.

Patient Signature: _____ Date: _____

Parent/Guardian Signature (if minor) _____ Date: _____

Managed Care / HMO Patients

I understand that it is my responsibility to obtain a valid referral from my primary care physician. I understand that if I do not obtain or have a referral on file that I may be held financially responsible for services received. I further understand that I am responsible for services that are considered non-covered expenses by my insurer.

Patient Signature: _____ Date: _____

Parent/Guardian Signature (if minor) _____ Date: _____

MEDICAL HISTORY

Date:_____
Name:_____

What **medications** do you currently take (RX or OTC)?
_____ see attached

_____

Have you had any major **illnesses or injuries** since your last visit?

_____

What **surgeries** have you had?

_____

Do you currently have any problems in the following areas? If yes, please provide information.

	YES	NO	Explanation of problem
EYES			
GENERAL/ CONSTITUTION			
EARS, NOSE, THROAT			
CARDIOVASCULAR			
RESPIRATORY			
GASTROINTESTINAL			
GENITAL, KIDNEY, BLADDER			
MUSCLES, BONES, JOINTS			
SKIN			
NEUROLOGICAL			
PSYCIATRIC			
ENDOCRINE			
BLOOD, LYMPH			
ALLERGIC, IMMUNOLIGIC			

FAMILY – Any changes to family medical status (mother,father,siblings, etc)? YES_____ No_____
If yes, describe_____
SOCIAL – Any changes in employment?_____
Living Arrangements (independent, assisted living, etc)?_____

Do you drive? _____Yes _____No
Do you have visual difficulty when driving? _____Yes _____No
Do you have problems with night vision? _____Yes _____No
Do you drink alcohol? _____Yes _____No If yes, frequency _____
Do you smoke? _____Yes _____No If yes, frequency _____

NeuroEyeOrbit Institute

8631 W. 3rd Street, Suite 200E
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Acknowledgement - HIPPA Rules & Regulation

I hereby acknowledge that I have been offered a copy of NeuroEyeOrbit Institute's notice of Privacy Practices as required by the Health Insurance Portability and Accountability Act (HIPPA).

Signature: _____

Name:_____

Date:_____

NeuroEyeOrbit **Institute**

date: _____

Contact Information

May we contact you regarding future appointments by an automated system reminder?

YES or **NO**

Assignment of Benefits

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled including Medicare, private insurance, and any other health plans to NeuroEyeOrbit Institute. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize the said assignee to release all information necessary to secure payment.

Initial: _____

Payment and Insurance Policy

If you have an **insurance** carrier we will bill most insurance companies, however, you will be required to pay copayments, deductibles, co-insurance and non-covered charges. If you **do not have insurance**, payment is due at the time of service. If we are **not contracted** with your insurance company, please be aware that your benefits could significantly change or benefits could be denied entirely. If your insurance is a **managed care plan or an HMO** you are responsible for obtaining authorization before every visit. Once the claim has been submitted on your behalf, it is our policy to allow 60 days for reimbursement by your insurance company. If payment has not been received after 60 days, you will be required **to pay in full all remaining balances** on your account.

Initial: _____

Cancellation Policy

In order to serve our patients better, we have instituted a cancellation policy. We require 24 hour notice for all cancellations. As a courtesy, reminder calls are made 1 day before your appointment to allow you to contact us in the event you need to cancel or reschedule your appointment. If an appointment is missed, cancelled or rescheduled without 24 hour notice there will be a $25.00 charged billed to the patient. By signing below, I am acknowledging that I have been notified of the cancellation policy,

Initial: _____

Patient Name: _____ Signature: _____