PATIENT INFORMATION

DEMOGRAPHICS

NAME LAST FIRST MI				BIRTHDATE	AGE	SEX
STREET ADDRESS				SOCIAL SECURITY #		
CITY	STATE	COUNTY	ZIP CODE	SPECIAL NEEDS (CIRCLE ONE) WHEEL CHAIR WALKER HEARING IMPAIRED TRANSLATOR LANGUAGE_____ OTHER		
HOME PHONE ( )	WORK/CELL PHONE ( )	EMAIL ADDRESS		(CIRCLE ONE) AMERICAN INDIAN/ALASKA ASIAN WHITE AFRICAN AMERICAN NATIVE HAWAIIAN PACIFIC ISLANDER		HISPANIC YES NO
EMPLOYER NAME/ADDRESS	POSITION			MARITAL STATUS (CIRCLE ONE) MARRIED DIVORCED SINGLE WIDOWED		
SPOUSE				WORK PHONE		
EMERGENCY CONTACT				EMERGENCY PHONE		
PRIMARY PHARMACY	ADDRESS			PHARMACY PHONE		

BILLING

GUARANTOR (FINANCIALLY RESPONSIBLE PERSON)				RELATIONSHIP TO PATIENT (CIRCLE ONE) SELF SPOUSE PARENT OTHER	
STREET ADDRESS				PHONE ( )	
CITY				STATE	ZIP CODE
PRIMARY INSURANCE	POLICY HOLDER	POLICY ID#	SOCIAL SECURITY #		INSURED'S B/D
SECONDARY INSURANCE	POLICY HOLDER	POLICY ID#	SOCIAL SECURITY #		INSURED'S B/D
SEND WORKERS COMPENSATION TO		AUTHORIZED BY/POSITION		DATE OF INCIDENT	

REFERRAL

WHOM MAY WE THANK FOR TELLING YOU ABOUT OUR PRACTICE? NAME:	(CIRCLE ONE) FRIEND/FAMILY NEWSPAPER RADIO TV YELLOW PAGES WEBSITE MOVIE AD HEALTH FAIR INSURANCE OTHER_____ MD/DO_____ OPTOMETRIST_____
I GIVE MY PERMISSION FOR MOYES EYE CENTER TO SEND A THANK YOU LETTER TO MY REFERRAL. SIGNATURE:	
PRIMARY CARE DOCTOR NAME	PHONE NUMBER

STREET ADDRESS	CITY	STATE	ZIP CODE

YOUR OCULAR HISTORY

Yes	No		Yes	No		Yes	No	
☐	☐	Cataracts	☐	☐	Cataract Surgery DATE _____	☐	☐	Crossed eyes / Lazy eye
☐	☐	Glaucoma	☐	☐	Glaucoma Surgery _____	☐	☐	Iritis / Uveitis
☐	☐	Corneal Disease	☐	☐	Corneal Surgery _____	☐	☐	Eye Muscle Surgery DATE _____
☐	☐	Retinal Disease	☐	☐	Retinal Surgery _____	☐	☐	Other: _____

Please list all ocular medications you are **currently taking**:

_____

Please list all Medications you are **currently taking**:

_____

_____

_____

_____

Please list all Medications you are **allergic** to:

_____

_____

_____

_____

YOUR SOCIAL HEALTH HISTORY

Yes ☐ No ☐ Do you or did you smoke? Yes ☐ No ☐ Do you drink alcohol? Yes ☐ No ☐ Do you use recreational drugs?

YOUR HEALTH HISTORY

Yes	No		Yes	No	
☐	☐	Asthma _____	☐	☐	Head or Spinal injuries _____
☐	☐	Kidney Disease _____	☐	☐	Seizures, Convulsions, or Fainting _____
☐	☐	Tuberculosis _____	☐	☐	Extensive Confinement by Illness or Injury _____
☐	☐	Diabetes _____	☐	☐	Temporal Arteritis _____
☐	☐	Migraines _____	☐	☐	Carotid Artery Disease _____
☐	☐	Psychiatric Disorder _____	☐	☐	Stroke _____
☐	☐	Nervous Disorder _____	☐	☐	HIV _____
☐	☐	Heart Disease _____	☐	☐	Liver Disease _____
☐	☐	Ulcer _____	☐	☐	Rheumatoid Arthritis _____
☐	☐	High Blood Pressure_____	☐	☐	Cancer _____
☐	☐	Do you smoke?_____	☐	☐	Sickle Cell Anemia_____
☐	☐	Do you drink? _____	☐	☐	Other Diagnosed Health Problems_____
☐	☐	Taken any illegal substances within the last 12 months?			_____

FAMILY HISTORY

M=MOTHER F=FATHER S=SISTER B=BROTHER A=AUNT U=UNCLE
(circle all that apply)

Yes	No			Yes	No			Yes	No		
☐	☐	Cataracts	M F S B A U	☐	☐	Macular Degeneration	M F S B A U	☐	☐	Heart Disease	M F S B A U
☐	☐	Glaucoma	M F S B A U	☐	☐	Retinitis Pigmentosa	M F S B A U	☐	☐	Stroke	M F S B A U
☐	☐	Corneal Disease	M F S B A U	☐	☐	Retinal Detachment	M F S B A U	☐	☐	Diabetes	M F S B A U
								☐	☐	Other:_____	M F S B A U

SURGICAL HISTORY (please include date & type)

Name:_____ DOB: _____ **Date:**_____

Tech initial & date_____

Agreement of Financial Responsibility

I understand that professional services are rendered to the patient and the patient is finacially responsible for charges incurred for these services. Payment for annual deductibles and co-insurance will be collected at check in. Glasses prescriptions are considered "routine services" and are not covered by most "medical" health insurances. A $25 refractive fee will be charged for printed prescriptions. Please be prepared to pay for this service at your appointment. I understand that I am financially responsible for charges not covered by my insurance company.

Release of Information/Assignment of Benefits

I authorize use of this form on all my insurance submissions and authorize release of information needed to process a claim to all my insurance companies. I permit a copy of this authorization to be used in place of the original. I authorize the provider to act as my agent in helping me obtain payment from my insurance companies. I understand the provider does not accept responsibility for collecting my insurance claims or for negotiating a settlement on disputed claims. I assign all rights and claims for reimbursement of expenses allowable under my insurance plan and authorize payment directly to the provider for services rendered. I understand I will receive a monthly statement for any balance due by me.

Medicare Authorization

I request payment of authorized Medicare benefits be made on my behalf to Moyes Eye Center, PC, for any services furnished to me by that physician/supplier. I authorize the holder of medical information, about me, to release to Medicare and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand that 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 the release of the information to the insurer to the agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance and the uncovered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Medigap Authorization

The following is to be filled out if you have a Medigap insurance policy for which you wish to assign benefits. A Medigap or Medicare Supplemental policy is a health insurance policy or other health plan, offered by a private company, to those entitled to Medicare benefits. It is designed to pay certain costs that Medicare does not pay. By law, this excludes a policy or plan offered by an employer to employees or former employees, as well as a policy or plan offered by a labor organization to members or former members.

Consent to Treat

I voluntarily consent to such care and treatment as prescribed by the physician as is necessary in his/her judgement as it pertains to my eyecare.

This agreement is in effect until revoked in writing by the patient.

Name:_____ Date:_____

Signature:_____ DOB: _____

HIPAA PATIENT NOTICE

HIPAA is an acronym for the Health Insurance Portability & Accountability Act of 1996 (a federal law). Of significant concern to healthcare organizations is the Administrative
Simplification section of the Act, which requires healthcare organizations to comply with specific rules regarding:

- Unique Identifiers for health plans, providers, individuals, employers
- Healthcare Transaction & Code Sets for transmitting data electronically
- Privacy regulations over disclosure and use of health information
- Security regulations over protections of electronic health information

It is our policy to not release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voice mail, cell phone and/or pager. Whenever returning phone calls and the answering machine picks up, we do not leave a message if the name or the telephone number is not on the recorded message to identify the residence. Information will also not be left with an unauthorized person who may answer the telephone. If you would like information released to someone other than yourself please complete the following:

I authorize Moyes Eye Center to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever the information changes.

Home telephone	yes_____	no_____
Answering machine	yes_____	no_____
Work telephone	yes_____	no_____
Voice mail	yes_____	no_____
Cell phone and/or voice mail	yes_____	no_____
Pager	yes_____	no_____
Can we fax medical records for referrals?	yes_____	no_____

Please list names of people we can discuss your medical care with:

Spouse:_____ yes_____ no_____

Parent:_____ yes_____ no_____

Other:_____
Please give name and relationship such as boyfriend, sister, etc.

_____ _____
Signature Patient/Guardian Date

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEGEMENT FORM

I, _____, have received a copy of Moyes Eye Center Notice of Privacy Practices.
Patient Name

I, _____, refuse to accept a copy of Moyes Eye Center Notice of Privacy Practices.
Patient Name

Patient Name _____

DOB _____

_____
Signature of Patient Date