NEW PATIENT INFORMATION RECORD

Full Name: _____ SS#: _____

DOB: _____ Sex: _____ Marital Status: _____

Address: _____City: _____ State: ____ Zip: _____

Email: _____ Home Phone: _____ Cell: _____

Primary Care Doctor: _____

Emergency Contact: _____ Phone: _____

Relationship to patient: _____

If patient is a minor, the following information must be filled out by parent or guardian:

Parent 1: _____ Parent 2: _____

Address: _____ Address: _____

SS#: _____ DOB: _____ SS#: _____ DOB: _____

Home#: _____ Cell: _____ Home#: _____ Cell:_____

INSURANCE INFORMATION: (Insurance cards must be presented at EVERY visit)

Primary: _____ ID#: _____ Group: _____

Subscriber's Name: _____ SS#: _____ DOB: _____

Subscriber's Employer: _____

Secondary: _____ ID#: _____ Group: _____

Subscriber's Name: _____ SS#: _____ DOB: _____

Subscriber's Employer: _____

I hereby authorize Hometown Ophthalmology to treat my dependents or myself. I also authorize Hometown Ophthalmology to furnish information to insurance carriers concerning my/their illness and treatments. This authorization is valid as long as I am a patient of Hometown Ophthalmology. I understand that I am responsible for all financial obligations of health services for the above patient, and for reimbursement and payment of claims from my insurance company. If my account is placed for collection with a third party collection agency, I agree to be responsible for the pre and post-judgment interest, attorney fees and court costs. I understand and agree to the above terms. I have received a Notice of Privacy Practices from Hometown Ophthalmology.

Signature of Patient/Responsible Party: _____ Date: _____

MEDICARE PATIENTS

I request that payment of authorized Medicare benefits be made to me or on my behalf to Hometown Ophthalmology for any services furnished to me by that provider. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

_____ _____

Patient/Representative's Signature Date

MEDICARE SECONDARY INSURANCE

I request that payment of authorized Medicare benefits be made either to me or to Hometown Ophthalmology on my behalf for any services rendered to me by that provider. I authorize any holder of medical information about me to release to my secondary insurance any information to determine these benefits or the benefits payable for related services.

_____ _____

Patient/Representative's Signature Date

HOMETOWN OPHTHALMOLOGY

PATIENT MEDICAL HISTORY FORM

Patient Name: _____ **DOB:** _____

Primary Care Doctor/Nurse Practitioner: _____

Specialists: _____

Medical History: (Circle all that apply):

Diabetes	Heart Disease	Cancer	Seasonal Allergies	High Blood Pressure
History of Stroke	Bladder/Prostate Issues	Thyroid Disease	Blood Clots	Headaches
Lung Disease	Kidney Disease	Autoimmune Disease	High Cholesterol	Reaction to Anesthesia

Other: _____

Eye History: (Circle all that apply):

Glaucoma Retinal Detachment Macular Degeneration Blindness Dry Eye

Other: _____

Have you ever been treated with injections in your eye? YES NO

Past Surgeries (including eye surgeries): _____

_____

Drug Allergies: _____

Do you smoke?: YES NO **Do you drink alcohol daily?:** YES NO

Medications you currently take: (You can supply a list instead): _____

_____

_____

Have any of your FAMILY MEMBERS been diagnosed with any of the following?: (Circle all that apply):

Glaucoma Macular Degeneration Retinal Detachment Blindness

Other eye diseases: _____

Are you interested in contacts today?: YES NO

Do you wear contact lenses?: YES NO **Type:** SOFT RGP **Hours worn per day?**: _____

What solution do you use?: _____

How often do you replace your contacts?: _____

Are you interested in purchasing glasses today?: YES NO