

PATIENT INFORMATION

DEMOGRAPHICS

NAME LAST FIRST MI			DATE			
STREET ADDRESS			SOCIAL SECURITY #			
CITY			SPECIAL NEEDS <input type="checkbox"/> WHEEL CHAIR <input type="checkbox"/> WALKER <input type="checkbox"/> HEARING IMPAIRED <input type="checkbox"/> OTHER <input type="checkbox"/> TRANSLATOR LANGUAGE _____			
STATE	COUNTY	ZIP CODE	BIRTHDATE	AGE	RACE	SEX
HOME PHONE () - -		WORK PHONE () - -		MARITAL STATUS <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOWED		
EMPLOYER NAME / ADDRESS				POSITION / DEPARTMENT		
SPOUSE				WORK PHONE () - -		
EMERGENCY CONTACT				EMERGENCY PHONE () - -		

BILLING

GUARANTOR (FINANCIALLY RESPONSIBLE PERSON) NAME			RELATIONSHIP TO PATIENT <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT <input type="checkbox"/> 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		<input type="checkbox"/> FRIEND / FAMILY <input type="checkbox"/> PROLOGUE <input type="checkbox"/> NEWSPAPER _____ <input type="checkbox"/> PATIENT <input type="checkbox"/> SIGN <input type="checkbox"/> RADIO _____ <input type="checkbox"/> YELLOW PAGES <input type="checkbox"/> SCREENING <input type="checkbox"/> OTHER _____	
I give my permission for Hunkeler Eye Centers to send a Thank You letter to my referral. Signature: _____		<input type="checkbox"/> MD / DO _____ <input type="checkbox"/> OPTOMETRIST _____	
STREET ADDRESS		CITY	STATE ZIP CODE
PRIMARY CARE DOCTOR NAME		FAMILY OPTOMETRIST NAME	PHONE () - -
STREET ADDRESS		CITY	STATE ZIP CODE

HEALTH HISTORY

Name: _____

Date: _____

<input type="checkbox"/>	<input type="checkbox"/>	Asthma _____	<input type="checkbox"/>	<input type="checkbox"/>	Head or Spinal Injuries _____
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease _____	<input type="checkbox"/>	<input type="checkbox"/>	Seizures, Convulsions, or Fainting _____
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis _____	<input type="checkbox"/>	<input type="checkbox"/>	Extensive Confinement by Illness or Injury _____
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes IDDM/ Type II _____ # of yrs _____	<input type="checkbox"/>	<input type="checkbox"/>	Temporal Arteritis _____
<input type="checkbox"/>	<input type="checkbox"/>	Insulin _____	<input type="checkbox"/>	<input type="checkbox"/>	Suffering from any other disease _____
<input type="checkbox"/>	<input type="checkbox"/>	Migraines _____	<input type="checkbox"/>	<input type="checkbox"/>	Carotid Artery Disease _____
<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Disorder _____	<input type="checkbox"/>	<input type="checkbox"/>	Permanent Defect from illness, Disease or injury _____
<input type="checkbox"/>	<input type="checkbox"/>	Any nervous disorder _____	<input type="checkbox"/>	<input type="checkbox"/>	(Women) Are you Pregnant? _____
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease _____	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure _____
<input type="checkbox"/>	<input type="checkbox"/>	Ulcer _____	<input type="checkbox"/>	<input type="checkbox"/>	Stroke _____
<input type="checkbox"/>	<input type="checkbox"/>	Hypertension _____ # of yrs _____	<input type="checkbox"/>	<input type="checkbox"/>	HIV _____
<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Anemia _____	<input type="checkbox"/>	<input type="checkbox"/>	Other Diagnosed Health Problems _____
<input type="checkbox"/>	<input type="checkbox"/>	Do you Smoke? _____	<input type="checkbox"/>	<input type="checkbox"/>	Do You Drink? _____
<input type="checkbox"/>	<input type="checkbox"/>	Within the last twelve (12) months have you taken any illegal substances? _____			

Please List All Medications You Are Currently TAKING : _____ _____ _____ _____	Please List All Medications You are ALLERGIC To: _____ _____ _____ _____
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YOUR OCULAR HISTORY (Have you been diagnosed with any of the following in the past?)

<input type="checkbox"/>	<input type="checkbox"/>	Cataracts _____	<input type="checkbox"/>	<input type="checkbox"/>	Cornea Disease _____
<input type="checkbox"/>	<input type="checkbox"/>	Retina Disease _____	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma _____
<input type="checkbox"/>	<input type="checkbox"/>	Crossed Eyes _____	<input type="checkbox"/>	<input type="checkbox"/>	Injury _____
<input type="checkbox"/>	<input type="checkbox"/>	Iritis _____	<input type="checkbox"/>	<input type="checkbox"/>	Other Eye Disorders _____

Cataract Surgery (Date of Surgery)	Right	Left	Do you have a lens implant? Yes No
Retina Surgery (Date of Surgery)	Right	Left	
Explanation of Eye injury: _____			

FAMILY HISTORY (Has anyone in your family (blood relative) had any of the following?)

(NOTE RELATION TO PATIENT) F - Father M - Mother P - Paternal M - Maternal S - Sister B - Brother
 GF - Grandfather GM - Grandmother U - Uncle A - Aunt

<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma _____	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes IDDM/ Type II _____
<input type="checkbox"/>	<input type="checkbox"/>	Cataracts _____	<input type="checkbox"/>	<input type="checkbox"/>	Heart _____
<input type="checkbox"/>	<input type="checkbox"/>	Cornea Disease _____	<input type="checkbox"/>	<input type="checkbox"/>	Diabetic Retinopathy _____
<input type="checkbox"/>	<input type="checkbox"/>	Macular Degeneration _____	<input type="checkbox"/>	<input type="checkbox"/>	Retinal Detachment _____
<input type="checkbox"/>	<input type="checkbox"/>	Retinitis Pigmentosa _____	<input type="checkbox"/>	<input type="checkbox"/>	Stroke _____
<input type="checkbox"/>	<input type="checkbox"/>	Other Eye Problems _____	<input type="checkbox"/>	<input type="checkbox"/>	Other General Health Problems _____

SURGICAL HISTORY (Please include Date & Type)

Tech Signature: _____

Agreement of Responsibility

I understand that professional services are rendered to the patient and the patient is responsible for charges incurred for these services. Payment for annual deductibles and co-insurance may be collected at the time of service. I understand that I am financially responsible for charges not covered by my insurance company.

Consent to Treat

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

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.

I understand that Novamed Eyecare Services, LLC ("NovaMed") has been engaged to manage Hunkeler Eye Centers, PC and hereby authorize NovaMed, its agents, employees and affiliates to have access to my complete medical records for the purpose of performing its management functions and as they deem necessary for so long as NovaMed is engaged as manager.

Medicare Authorization

I request payment of authorized Medicare benefits be made on my behalf to Hunkeler 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.

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

Name: _____ Date: _____

Signature: _____