THE EYE MD

The Eye MD
9010 Lorton Station Blvd, Suite 250
Lorton, Virginia 22079
571-285-2020

PATIENT INFORMATION

NAME:_____ **DATE**:_____

DATE OF BIRTH_____/_____/_____

ADDRESS: _____

_____ **MALE** _____**FEMALE** ___ **NON-BINARY** ___
City State

9 DIGIT ZIP CODE: _____---_____

MARITAL STATUS: single / married / widowed / divorced

PHONE:_____H / W / C **PHONE**:_____H / W / C

EMAIL:_____

EMPLOYER:_____**OCCUPATION**:_____

MEANINGFUL USE;

If 65 and over

○ Have you received the pneumonia vaccine?
○ Do you have a health care proxy if you cannot make medical decisions?

ETHNICITY
○ Hispanic or Latino
○ Not Hispanic or Latino
○ Decline to State

RACE
○ American Indian
○ Asian
○ Black or African American
○ Caucasian
○ Hispanic
○Native Hawaiian or Other Pacific Islander

PREFERRED LANGUAGE
○ English
○ Spanish
○ French
○ Other _____

Reason for your visit today? _____

Do you need to update your prescription for: _____glasses or _____contact lenses? _____ No (check one)

Primary Care Physician_____**Phone**_____

If referred, by whom? Doctor / Optometrist / Existing Patient / Family Member / Co-worker / Friend / Internet / Local Advertisement / Other_____

History and Intake Form

Past Medical History: (please circle all that apply)

Anxiety	Arthritis	Artificial Joints	Asthma
Atrial fibrillation	BPH	Bone Marrow Transplantation	Breast Cancer
Colon Cancer	COPD	Coronary Artery Disease	Depression
Diabetes Hemoglobin A1C	End Stage Renal Disease	GERD	Hearing Loss
Hepatitis	Hypertension	HIV/AIDS	Hypercholesterolemia
Hyperthyroidism	Hypothyroidism	Leukemia	Lung Cancer
Lymphoma	Pacemaker	Prostate Cancer	Radiation Treatment
Seizures	Stroke	Valve Replacement	None

Other _____

Past Surgical History: (please circle all that apply) **L= Left R = Right**

Appendectomy	Hip Replacement L R	Pancreas Removed
Bladder Removed	Knee Replacement L R	Prostate Biopsy
Mastectomy L R	Kidney Biopsy L R	Prostate Removed: Prostate Cancer
Lumpectomy L R	Kidney Stone Removed	TURP
Breast Biopsy L R	Kidney Transplant L R	Rectum: APR
Colectomy: Resection	Kidney Removed L R	Rectum: LAR
Colectomy: Diverticulitis	Liver Removed	Basal Cell Cancer Surgery
Colectomy: IBD	Liver Transplant	Melanoma Surgery
Gallbladder Removed	Liver Shunt	Skin Biopsy
Biological Valve Replacement	Ovaries Removed: Cancer	Squamous Cell Carcinoma Surgery
Coronary Artery Bypass	Ovaries Removed: Cyst	Spleen Removed
Heart Transplant	Ovaries: Tubal Ligation	Testicles Removed
Mechanical Valve	Ovaries Removed: Endometriosis	Hysterectomy: Fibroids
PTCA		

Ocular Surgery: (please circle all that apply) **L = Left Eye R = Right Eye**

		Year			Year			Year
Blepharoplasty	L R		LASIK	L R		Trabeculectomy	L R	
Cataract surgery	L R		PRK	L R		Tube shunt	L R	
Corneal transplant	L R		Ptosis repair	L R		Yag capsulotomy	L R	
DSAEK	L R		Punctal plugs	L R				
Eye Muscle Surgery	L R		Strabismus	L R				
Intravitreal injections	L R		Retinal laser	L R				

Pharmacy:

Name: _____

Phone Number: _____

Address: _____Zip Code_____

Medications: (Please list all current medications)

_____
_____
_____
_____

Allergies: (Please list all allergies)

_____
_____
_____
_____

Social History: (Please circle all that apply)

Cigarette Smoking:	Alcohol:
Never smoked	Do not drink at all
Quit: former smoker	Occasional drinks
Smokes less than 1 pack per day	1-2 drinks per day
Smokes daily	More than 3 drinks per day

Family History: (please circle all that apply) **M=Mother F=Father B=Brother S=Sister**

Blindness	M	F	B	S	Diabetes	M	F	B	S	Strabismus	M F B S
Cancer	M	F	B	S	Glaucoma	M	F	B	S		M F B S
Cataracts	M	F	B	S	Heart Disease	M	F	B	S		M F B S
CVA	M	F	B	S	Migraine	M	F	B	S		M F B S
Macular Degeneration M F B S										Retinal Detachment	M F B S

Review of Systems: Are you currently experiencing any of the following? (please check yes or no)

	System	YES	NO
Poor vision	Eyes		
Eye pain	Eyes		
Tearing	Eyes		
Redness	Eyes		
Jaw pain	Eyes		
Scalp tenderness	Eyes		
Amaurosis fugax	Eyes		
Loss of vision	Eyes		
Uncontrolled blood pressure	Cardiovascular		
Uncontrolled blood sugar	Endocrine		
Weight loss	Constitutional		
Stuffy nose	ENT		
Dry mouth	ENT		
Congestion	Respiratory		
Shortness of breath	Respiratory		
Upset stomach	Gastrointestinal		
Incontinence	Gastrointestinal		
Arthritis	Musculoskeletal		
Headache	Neurological		

Anxiety	Psychiatric		
Allergies	Allergic/Immunologic		

Other Symptoms: _____

Alerts: Are you currently experiencing any of the following? (please check yes or no)

Alert	YES	NO
Allergy to adhesive		
Allergy to lidocaine		
Allergy to Fluorescein		
Allergy to Dilation Drops		
Blood thinners		
Defibrillator		
Flomax		
MRSA		
Narrow angles		
Pacemaker		
Premedication prior to procedures		
Rapid heart beat with epinephrine		
Pregnancy or planning a pregnancy		
Artificial joints within past two years		
Steroid responder		

Other Symptoms: _____

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Assignment of Benefits

INSURANCE

I hereby authorize The Eye MD to apply for benefits on my behalf for covered services rendered. I certify that the information I have reported with regard to my insurance coverage is correct. I further authorize the release of any necessary information, including medical information for this or any related claim, to my insurance carrier, (or, in the case of Medicare Part B benefits to the Social Security Administration and Health Care Financing Administration). A copy of the authorization may be used in place of the original. **This authorization may be revoked by either me or my insurance carrier at any time.**

_____
Initials

ASSIGNMENT OF BENEFITS

I hereby authorize payment of all medical insurance benefits which are payable to me under the terms of my insurance policy to be paid directly to The Eye MD for services rendered. I further authorize the release of any information needed for processing my insurance claims. A copy of this authorization may be used in place of the original. **I understand and agree that I am financially responsible for charges not paid by my insurance company.**

_____
Initials

Returned Check Fee

I understand that if my check is returned for insufficient funds, I will be charged a fee of **$50.00** plus the original amount due.

_____
Initials

Appointment Policy

If you are unable to keep a scheduled office visit appointment, we ask that you please give us at least 24 hours notice. "Late Cancellation" or "No Show" appointments may be charged a $**50.00** fee.

_____
Initial

Refraction Fee Policy

Refraction – or the determination of an eyeglasses prescription – is routinely performed in our office. This is one of the most important parts of your eye examination. It is how we determine the best possible visual acuity and function of your eye. It is **NOT** part of the medical examination fee for an ophthalmologist. **Medicare** and many other insurance plans will not pay for the refraction service. You may need a refraction if you are experiencing any of the following problems:

- Blurry vision
- Trouble reading
- Current glasses are not strong enough
- You have never been seen by an eye doctor and your vision is not 20/20
- You have been told that you have cataracts
- The doctor finds that you are not 20/20
- Other reasons for which the doctor will discuss with you
- Cataract check

It is our experience that many insurance plans consider this a " vision-related" service, not a "medical" service and do not cover this. Medical insurance companies base their decision to pay on the member's specific plan benefits, which differ greatly. Due to time constraints, we are unable to check this in advance of your visit to the office.

Our refraction fee is $65.00. Our office policy is to collect the refraction fee at the time of the visit. We will bill your insurance company for the refraction. If your insurance company pays us for the refraction, then we will refund you this payment, minus any financial responsibility you have such as co-insurance or deductibles.

_____
Initials

_____ _____
Patient (or Guardian) Signature **Date**

_____
Printed Name

Authorization for the Use or Disclosure of Protected Health Information

This is a summary of our Notice of Privacy Practices. The entire text detailing our privacy practices is available for your review, and we encourage you to read it and ask any questions you may have regarding our privacy practices. If you have any questions or would like to exercise any of your rights, please contact our Privacy Officer. After reviewing the materials, please sign in the space provided below.

PATIENT RIGHTS

As a patient, you have a right to inspect, copy, amend, request a restriction, or revoke a prior restriction on the use and disclosure of your Protected Health Information (PHI). You may request a copy of any accounting of disclosures, which will detail all disclosures made for reasons other than treatment, payment, or health care operational purposes. You may request that we communicate with you only in a specific manner (i.e. "only communicate with me at my work telephone number").

PROVIDER RIGHTS

As your health care provider, we can use or disclose your PHI for treatment, payment, or health care operational purposes. Any other disclosure requires you to sign a specific authorization.

_____ _____

Patient (or Guardian) Signature **Date**

Printed Name **Date of Birth**

Patient Contact Authorization

In general, the HIPPA privacy policy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply)

Home telephone: _____

____OK to leave detailed message

____Leave message with call back number only

Work telephone:_____

____ OK to leave detailed message

____ Leave message with call back number only

Cell telephone: _____

____ OK to leave detailed message

____ Leave message with call back number only

You may discuss my medical history with:

Name and telephone number **Relationship to patient**

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosures. To assist us with this requirement, our office will only release information with a written request signed by the patient or legal guardian of said patient. This includes requests made by other physicians and their office(s). Our office will supply the proper form. **Note: Uses and disclosures for PHI may be permitted without prior consent in an emergency. All authorizations will be in effect until revoked in writing by the patient.**

Patient/Guardian Signature **Date**

Printed Name:_____