FLORAL PARK OPHTHALMOLOGY

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Phone: 516-616-1710, Fax: 516-616-1700
www.jindramd.com

PATIENT INFORMATION

LAST NAME: _____ FIRST NAME: _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK PHONE: _____

CELL: _____ E-MAIL: _____

SEX: M ☐ F ☐ MARTIAL STATUS: S ☐ M ☐ W ☐ D ☐ DATE OF BIRTH: _____/_____/_____ AGE: _____

SOC. SEC. #: _____ OCCUPATION: _____ EMPLOYED OR RETIRED

REFERRED BY: _____

REF. PHYSICIAN PHONE: _____ REF. PHYSICIAN FAX: _____

REF. PHYSICIAN ADDRESS: _____

EMERGENCY CONTACT: _____

RELATIONSHIP TO PATIENT: _____ PHONE/ CELL: _____

HAVE YOU OBTAINED REQUIRED AUTHORIZATION FOR OUR SERVICES? YES OR NO OR N/A

INSURANCE INFORMATION

PRIMARY INSURANCE CO. NAME: _____

ID#:_____ GROUP #: _____

SUBSCRIBER: _____ RELATIONSHIP: _____

SUBSCRIBER DOB: _____ SUBSCRIBER SS #: _____

EFFECTIVE DATE: _____ INS. CO. PHONE: _____

SECONDARY INSURANCE CO. NAME: _____

ID#:_____ GROUP #: _____

SUBSCRIBER: _____ RELATIONSHIP: _____

SUBSCRIBER DOB: _____ SUBSCRIBER SS #: _____

EFFECTIVE DATE: _____ INS. CO. PHONE: _____

SIGNATURE on FILE, ASSIGNMENT of BENEFITS, FINANCIAL AGREEMENT

_____ _____

Patient Name (print) Medicare Number

1. **MEDICARE**: I request that payment of authorized Medicare benefits be made on my behalf to Floral Park Ophthalmology for services furnished me by Floral Park Ophthalmology. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) and its agents any information needed to determine these benefits or the benefits payable for related services. I understand 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, my signature authorizes releasing the information to the insurer or agency shown. Floral Park Ophthalmology accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.
2. **MEDIGAP:** I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim form, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Floral Park Ophthalmology, if possible or otherwise to me.
3. **RELEASE OF INFORMATION:** Floral Park Ophthalmology may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to Floral Park Ophthalmology for reimbursement of services rendered, and (2) any health care provider for continued patient care. Floral Park Ophthalmology may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical date or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.
4. **OTHER INSURANCE:** I understand that Floral Park Ophthalmology maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office. To the best of our knowledge, Floral Park Ophthalmology has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Floral Park Ophthalmology if I belong to a plan that does not appear on the above mentioned list.
5. **NON-COVERED SERVICES:** I understand that Floral Park Ophthalmology's contracts with health service plans (i.e., HMOs, PPOs) relate only to items and services which are "covered" by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient; and treatment or tests not authorized by the health care service plan. The undersigned agrees to obtain necessary health care service plan authorizations/ referrals.
6. **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by Floral Park Ophthalmology, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Floral Park Ophthalmology for payment. I agree to be responsible for any "insufficient funds" bank fees that may apply to personal check payments. I understand that a fee of $25.00 will be applied to any bill should the payment be more then 30 days over due. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to Floral Park Ophthalmology. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Floral Park Ophthalmology. However, it is understood that the undersigned and/or the patient are primarily responsible for payment of my bill.
7. **HIPAA:** I have been advised that this office is HIPAA compliant and that my right to privacy as noted in the Notice of Privacy Practices in this office, will be protected to the full extent of the law. Said notice provides information about how this office uses and discloses protected health information about me namely for treatment, payment or health care operations. My rights to request and discuss restrictions to the disclosure of protected health information about me are available.
8. **REFERRALS:** If my health care services plan requires prior approval / referrals, I understand that it is my responsibility to obtain it prior to the day of my appointment. If the referral is not received by Floral Park Ophthalmology, I understand that my appointment may be cancelled until such time that it is received or I will be responsible for any fees associated with the office visit.

_____ _____

Patient Signature or Authorized Party Date

_____

Authorized Party Print Name

MEDICAL HISTORY QUESTIONNAIRE

PATIENT NAME: _____ DATE: _____ DOB: _____

CHIEF COMPLAINT: _____

OCULAR HISTORY:

DRY EYE: _____

CATARACT: _____

GLAUCOMA: _____

LAZY EYE: _____

MACULAR DEGENERATION: _____

DETACHED RETINA: _____

DIABETIC RETINOPATHY: _____

DATE OF LAST EYE EXAM: _____

MEDICAL HISTORY:

DIABETES: _____

HYPERTENSION: _____

HEART DISEASE: _____

ASTHMA: _____

STEROID USE: _____

OTHER: _____

_____

HISTORY OF EYE SURGERY (DETAILS & DATES): _____

HISTORY OF EYE INJURY (DETAILS & DATES): _____

ALLERGIES TO FOOD:_____

ALLERGIES TO MEDICATION:_____

FAMILY HISTORY

Has any member of your family had these diseases (check all that apply) ?

	Mother	Father	Grandparent	Sibling		Mother	Father	Grandparent	Sibling
Blindness	_____	_____	_____	_____	Heart Disease	_____	_____	_____	_____
Cataract	_____	_____	_____	_____	Stroke	_____	_____	_____	_____
Glaucoma	_____	_____	_____	_____	Cancer	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	Thyroid Disease	_____	_____	_____	_____
Hypertension	_____	_____	_____	_____	Arthritis	_____	_____	_____	_____

Other heritable disease: _____

SOCIAL HISTORY

Does your vision limit any activities of daily living (driving, reading, sports, work, etc.) YES NO

Have you ever had a blood transfusion? ... YES NO

Do you drink alcohol? …….. YES NO If YES how much? _____

Do you smoke? ……. YES NO If YES how much? _____ How many years? _____

PATIENT NAME: _____ DOB: _____

Review of Systems: Do you currently have any problems in the following areas? If YES, please provide additional information.

	YES	NO	DETAILS
EYES (poor vision, eye pain, tearing, redness, etc.)			
GENERAL / CONSTITUTIONAL (fever, weight loss, weight gain, unusually tired)			
EARS, NOSE, THROAT (hard of hearing, stuffy nose, ear ache, cough, dry mouth, etc.)			
CARDIOVASCULAR (high BP, racing pulse, heart attack, bypass surgery, atrial abrilliation, etc.)			
RESPIRATORY (congestion, wheezing, short of breath, asthma, emphysema, COPD etc.)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcer, etc.)			
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, yellow jaundice, etc.)			
FEMALES Are you pregnant? Nursing?			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, osteoporosis, etc.)			
SKIN (pimples, warts, growths, rash, eczema, psoriasis, etc.)			
NEUROLOGICAL (numbness, headache, seizures, paralysis, stroke, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (diabetes, hypothyroid, etc.			
BLOOD / LYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)			
ALLERGIC / IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)			

_____

Patient Signature or Authorized Party Date

_____

Physician's Signature Date