PATIENT INFORMATION

DEMOGRAPHICS

NAME LAST FIRST MI				DATE		
STREET ADDRESS				SOCIAL SECURITY #		
CITY				SPECIAL NEEDS ☐ WHEEL CHAIR ☐ WALKER ☐ HEARING IMPAIRED ☐ OTHER ☐ TRANSLATOR LANGUAGE _____		
STATE	COUNTY	ZIP CODE	BIRTHDATE	AGE	RACE	SEX
HOME PHONE ( ) -	WORK PHONE ( ) -			MARITIAL STATUS ☐ MARRIED ☐ DIVORCED ☐ SINGLE ☐ WIDOWED		
EMPLOYER NAME / ADDRESS				PATIENT EMAIL ADDRESS		
SPOUSE				WORK PHONE ( ) -		
EMERGENCY CONTACT				EMERGENCY PHONE ( ) -		

BILLING

GUARANTOR (FINANCIALLY RESPONSIBLE PERSON) NAME			RELATIONSHIP TO PATIENT ☐ 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		☐ FRIEND / FAMILY ☐ PROLOGUE ☐ NEWSPAPER _____ ☐ PATIENT ☐ SIGN ☐ RADIO ☐ YELLOW PAGES ☐ SCREENING ☐ OTHER _____	
I give my permission for Hunkeler Eye Centers to send a Thank You letter to my referral. Signature:		☐ MD / DO _____ ☐ 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: _____

Yes	No		Yes	No	
☐	☐	Asthma _____	☐	☐	Head or Spinal Injuries _____
☐	☐	Kidney Disease _____	☐	☐	Seizures, Convulsions, or Fainting _____
☐	☐	Tuberculosis _____	☐	☐	Extensive Confinement by Illness or Injury _____
☐	☐	Diabetes IDDM/ Type II _____# of yrs__	☐	☐	Temporal Arteritis _____
☐	☐	Insulin _____	☐	☐	Suffering from any other disease _____
☐	☐	Migraines _____	☐	☐	Carotid Artery Disease _____
☐	☐	Psychiatric Disorder _____	☐	☐	Permanent Defect from illness, Disease or injury _
☐	☐	Any nervous disorder _____	☐	☐	(Women) Are you Pregnant? _____
☐	☐	Heart Disease _____	☐	☐	High Blood Pressure _____
☐	☐	Ulcer _____	☐	☐	Stroke _____
☐	☐	Hypertension _____# of yrs__	☐	☐	HIV _____
☐	☐	Sickle Cell Anemia _____	☐	☐	Other Diagnosed Health Problems _____
☐	☐	Do you Smoke? _____	☐	☐	Do You Drink? _____
☐	☐	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:
_____	_____
_____	_____
_____	_____
_____	_____

YOUR OCULAR HISTORY (*Have you been diagnosed with any of the following in the past?*)

Yes	No		Yes	No	
☐	☐	Cataracts _____	☐	☐	Cornea Disease _____
☐	☐	Retina Disease _____	☐	☐	Glaucoma _____
☐	☐	Crossed Eyes _____	☐	☐	Injury _____
☐	☐	Iritis _____	☐	☐	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

Yes	No		Yes	No	
☐	☐	Glaucoma _____	☐	☐	Diabetes IDDM/ Type II _____
☐	☐	Cataracts _____	☐	☐	Heart _____
☐	☐	Cornea Disease _____	☐	☐	Diabetic Retinopathy _____
☐	☐	Macular Degeneration _____	☐	☐	Retinal Detachment _____
☐	☐	Retinitis Pigmentosa _____	☐	☐	Stroke _____
☐	☐	Other Eye Problems _____	☐	☐	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:_____