Patient Information

Demographics

NAME LAST FIRST MI			DATE	
STREET ADDRESS APT#			SOCIAL SECURITY#	
CITY			SPECIAL NEEDS ☐ WHEEL CHAIR ☐ WALKER ☐ HEARING IMPAIRED ☐ OTHER ______ ☐ TRANSLATOR LANGUAGE ______	
STATE	ZIP CODE	BIRTH DATE	AGE	SEX ☐ F ☐ M
HOME PHONE ( ) -	WORK PHONE ( ) -	EMAIL ADDRESS	MARITAL STATUS ☐ MARRIED ☐ DIVORCED ☐ SINGLE ☐ WIDOWED	
EMPLOYER NAME/ADDRESS			POSITION/DEPARTMENT	
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#	SS#	INSURED'S B/D
SECONDARY INSURANCE	POLICY HOLDER	POLICY ID#	SS#	INSURED'S B/D
SEND WORKERS' COMPENSATION BILL TO	AUTHORIZED BY/POSITION		DATE OF INCIDENT	

Referral

WHOM MAY WE THANK FOR TELLING YOU ABOUT OUR PRACTICE? NAME	☐ FRIEND/FAMILY ☐ PROLOGUE ☐ NEWSPAPER ______ ☐ M.D. ☐ SIGN ☐ RADIO ______ ☐ OPTOMETRIST ☐ SCREENING ☐ OTHER ______ ☐ PATIENT ☐ YELLOW PAGES		
STREET ADDRESS	CITY	STATE	ZIP CODE
PRIMARY CARE DOCTOR NAME		PHONE ( ) -	
STREET ADDRESS	CITY	STATE	ZIP CODE

MG 1066-115

Consent to Treat

I voluntarily consent to such care and treatment as prescribed by the physician as is necessary in her/her medical 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 Deborah R. DiStefano, MD, PC has been engaged to manage Omni Eye Services and hereby authorize Deborah R. DiStefano, MD, PC, her agents, employees and affiliates to have access to my complete medical records for the purpose of performing management functions and as they deem necessary for so long as Deborah R. DiStefano, MD, PC is engaged as manager.

Medicare Authorization **Medicare No:** ______________________

I request payment of authorized Medicare benefits be made on my behalf to Deborah R. DiStefano, MD, PC for any services furnished 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 or 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 **Insurance Co:** ______________________
Policy #: ______________________

Fill 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 benefit 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 employed, as well as a policy or plan offered by a labor organization to members or former members.

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. If I default on payment for professional services rendered, I will be responsible for all charges incurred if a collection agency is used to collect payment.

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

Name: ______________________________ Date: ______________________

Signature: ______________________________

PATIENT HISTORY FORM

Do you have any food or drug allergies?

No_____ Yes_____, please list_______________________________

Do you use tobacco, alcohol or recreational drugs?

No_____ Yes_____, please list_______________________________

Does anyone in your family have the following?

Glaucoma_____ Diabetes_____ Crossed eyes_____ Blindness_____

Cancer_____ Heart Disease_____ None_____

Other____

Please List all medications you take:

Medication	Dosage	Reason you take this

List all previous operations / treatments / injuries / illness

Date	Description

Name_______________________ DOB__________ Date__________

REVIEW OF SYSTEMS

Please check those things which apply to you.

Eyes

- ❑ Glasses
- ❑ Contacts
- ❑ Pain
- ❑ Redness
- ❑ Discharge
- ❑ Tearing
- ❑ Itching
- ❑ Swelling
- ❑ Light Sensitivity
- ❑ Floaters
- ❑ Double Vision
- ❑ Distortion
- ❑ Loss of Color
- ❑ NONE

Cardiovascular

- ❑ Chest pain / Angina
- ❑ Heart attack
- ❑ High blood Pressure
- ❑ Irregular heartbeat
- ❑ Heart murmur
- ❑ NONE

Respiratory

- ❑ Asthma
- ❑ Emphysema
- ❑ Shortness of breath
- ❑ Productive cough
- ❑ Turberculosis
- ❑ NONE

Musculoskeletal

- ❑ Muscle cramps / Spasm
- ❑ Weakness
- ❑ Arthritis
- ❑ Aching joints
- ❑ Swelling joints
- ❑ NONE

Gastrointestinal

- ❑ Special diet
- ❑ Abdominal pain
- ❑ Indigestion
- ❑ Nausea / Vomiting
- ❑ Liver disease
- ❑ Diarrhea / Constipation
- ❑ Passing blood
- ❑ Change in stool color
- ❑ NONE

Genitourinary

- ❑ Kidney stones
- ❑ Infections
- ❑ Burning urine
- ❑ Genital discharge
- ❑ Dialysis
- ❑ NONE

Endocrine

- ❑ Excessive sweating
- ❑ Heat / cold intolerance
- ❑ Severe thirst
- ❑ Altered Menstrual cycle
- ❑ Infertility
- ❑ NONE

- ❑ HIV Positive

Constitutional Problems

- ❑ Fatigue
- ❑ Fever
- ❑ Weight Loss
- ❑ Loss of appetite
- ❑ NONE

Skin and / or Breast

- ❑ Rashes
- ❑ Change in skin color
- ❑ Loss of hair
- ❑ Breast lumps / surgery
- ❑ NONE

Diabetes controlled by

- ❑ Diet
- ❑ Insulin
- ❑ Oral medication
- ❑ NONE

Ear/Nose/Mouth/Throat

- ❑ Ringing ears
- ❑ Difficulty hearing
- ❑ Difficulty chewing
- ❑ Difficulty swallowing
- ❑ Difficulty speaking
- ❑ NONE

Psychiatric

- ❑ Memory Loss
- ❑ Poor concentration
- ❑ Sleeplessness
- ❑ Early waking
- ❑ Depression
- ❑ Anxiety attacks
- ❑ NONE

Neurological

- ❑ Stroke
- ❑ Epilepsy
- ❑ Headaches / Migraines
- ❑ Loss of balance
- ❑ Numbness / Tingling
- ❑ Tremors
- ❑ NONE

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NAME ______________________ DOB ____________ DATE ____________

DiStefano Regional Eye Center
Omni Eye Services of Chattanooga
1801 Gunbarrel Road
Chattanooga, Tennessee 37421
(423) 648-3937

Wavier of Financial Responsibility

I understand that professional services are rendered to the patient and ultimately the patient is responsible for charges incurred for these services. If the patient has no insurance coverage, or our office has not received a referral for the date of service, the patient will be **solely responsible** for the charges, which are due at the time of service. Payment for annual deductibles, co-insurance, and co-pays may be collected at the time services are rendered. I understand that I am fully responsible for any charges that are not covered by insurance.

By signing below, I am in full agreement that I am responsible for any charges incurred in my treatment.

____

Patient Signature/ Responsible Party

____

Patient Services Representative

____

Date

Patient Name (Please Print)________________________________ Date of Birth ______________

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge that I have received the Privacy Notice.

____________________________ ________________
Patient or Personal Representative Signature Date

____
Patient Name

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient:

____

I authorize the release of my medical information to the following person(s):

Name	Relationship	Date