

Patient Information

Demographics

NAME LAST FIRST MI			DATE		
STREET ADDRESS APT#			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	ZIP CODE	BIRTH DATE	AGE	SEX <input type="checkbox"/> F <input type="checkbox"/> M	
HOME PHONE () - -	WORK PHONE () - -	EMAIL ADDRESS		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#	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		<input type="checkbox"/> FRIEND/FAMILY	<input type="checkbox"/> PROLOGUE	<input type="checkbox"/> NEWSPAPER _____
		<input type="checkbox"/> M.D.	<input type="checkbox"/> SIGN	<input type="checkbox"/> RADIO _____
		<input type="checkbox"/> OPTOMETRIST	<input type="checkbox"/> SCREENING	<input type="checkbox"/> OTHER _____
		<input type="checkbox"/> PATIENT	<input type="checkbox"/> YELLOW PAGES	
STREET ADDRESS		CITY	STATE	ZIP CODE
PRIMARY CARE DOCTOR NAME			PHONE () - -	
STREET ADDRESS		CITY	STATE	ZIP CODE

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 <input type="checkbox"/> Glasses <input type="checkbox"/> Tearing <input type="checkbox"/> Double Vision <input type="checkbox"/> Contacts <input type="checkbox"/> Itching <input type="checkbox"/> Distortion <input type="checkbox"/> Pain <input type="checkbox"/> Swelling <input type="checkbox"/> Loss of Color <input type="checkbox"/> Redness <input type="checkbox"/> Light Sensitivity <input type="checkbox"/> NONE <input type="checkbox"/> Discharge <input type="checkbox"/> Floaters		
Cardiovascular <input type="checkbox"/> Chest pain / Angina <input type="checkbox"/> Heart attack <input type="checkbox"/> High blood Pressure <input type="checkbox"/> Irregular heartbeat <input type="checkbox"/> Heart murmur <input type="checkbox"/> NONE	Respiratory <input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Productive cough <input type="checkbox"/> Tuberculosis <input type="checkbox"/> NONE	Musculoskeletal <input type="checkbox"/> Muscle cramps / Spasm <input type="checkbox"/> Weakness <input type="checkbox"/> Arthritis <input type="checkbox"/> Aching joints <input type="checkbox"/> Swelling joints <input type="checkbox"/> NONE
Gastrointestinal <input type="checkbox"/> Special diet <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea / Vomiting <input type="checkbox"/> Liver disease <input type="checkbox"/> Diarrhea / Constipation <input type="checkbox"/> Passing blood <input type="checkbox"/> Change in stool color <input type="checkbox"/> NONE	Genitourinary <input type="checkbox"/> Kidney stones <input type="checkbox"/> Infections <input type="checkbox"/> Burning urine <input type="checkbox"/> Genital discharge <input type="checkbox"/> Dialysis <input type="checkbox"/> NONE	Endocrine <input type="checkbox"/> Excessive sweating <input type="checkbox"/> Heat / cold intolerance <input type="checkbox"/> Severe thirst <input type="checkbox"/> Altered Menstrual cycle <input type="checkbox"/> Infertility <input type="checkbox"/> NONE <input type="checkbox"/> HIV Positive
Constitutional Problems <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever <input type="checkbox"/> Weight Loss <input type="checkbox"/> Loss of appetite <input type="checkbox"/> NONE	Skin and / or Breast <input type="checkbox"/> Rashes <input type="checkbox"/> Change in skin color <input type="checkbox"/> Loss of hair <input type="checkbox"/> Breast lumps / surgery <input type="checkbox"/> NONE	Diabetes controlled by <input type="checkbox"/> Diet <input type="checkbox"/> Insulin <input type="checkbox"/> Oral medication <input type="checkbox"/> NONE
Ear/Nose/Mouth/Throat <input type="checkbox"/> Ringing ears <input type="checkbox"/> Difficulty hearing <input type="checkbox"/> Difficulty chewing <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Difficulty speaking <input type="checkbox"/> NONE	Psychiatric <input type="checkbox"/> Memory Loss <input type="checkbox"/> Poor concentration <input type="checkbox"/> Sleeplessness <input type="checkbox"/> Early waking <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety attacks <input type="checkbox"/> NONE	Neurological <input type="checkbox"/> Stroke <input type="checkbox"/> Epilepsy <input type="checkbox"/> Headaches / Migraines <input type="checkbox"/> Loss of balance <input type="checkbox"/> Numbness / Tingling <input type="checkbox"/> Tremors <input type="checkbox"/> NONE

MG 1066-114

NAME _____ DOB _____ DATE _____

DiStefano Regional Eye Center

1801 Gunbarrel Road
Chattanooga, TN 37421

Laser Evaluation

Name _____ Age _____ Date _____

Do you wear contacts? Yes / No

If so, do you wear: Soft, Gas Permeable, Bifocal, Mono Vision (Circle One)

How many days has it been since you wore lenses? _____

Do you wear glasses? Yes / No

If so, do you wear: Bifocals or Readers (Circle One)

When was your last eye exam? _____

Who is your medical doctor? _____

Please list any health problems _____

Please list all medications you are currently taking _____

Please list all eye medications you are currently using _____

Do you have a history of eye illnesses? (If so, please list) _____

Have you ever had any eye surgery? (If so, please list) _____

Are you allergic to any medicines? (If so, please list) _____

What are your reasons for having laser surgery? _____

What are your expectations? _____

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 _____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____