Patient Information

PATIENT NAME: ____ DATE: _____________
First Last

HOME ADDRESS: ____
Street Apt. #

____AGE: _________ SEX: _________
City State Zip Code

Date of Birth: _____________________________ Social Security #: ____________________________

Home Phone: (_____)__________________________ Work Phone: (_____)____________________________
If you do not have a work phone, we still require a second phone #

Cellular Phone :(____) ______________________ Pager: (_____) __________________________

Email Address:____

Drivers License #: ____

Marital Status: ____________________________Maiden Name if Applicable: ______________________

Spouse's Name: _____________________________ Spouse's Work Phone: ________________________

Spouse's Date of Birth: _______________________ Spouse's Social Security #: ______________________

Who recommended us? ☐ Doctor ☐ Friend/Relative ☐ Yellow Pages ☐ Newspaper ☐ Other

____
Name

____
Address Telephone #

If Yellow Pages or Newspaper _____________________________ ______________________________
Which one? Please Specify

Name of Primary Care Physician: ____

Address:____

Telephone #: (________)_____________________________

Name of Optometrist: ____

Address: ____

Telephone #: (________)_____________________________

Name of Ophthalmologist: ____

Address: ____

Telephone #: (________)_____________________________

Name of Pharmacy: ____

Address:____

Telephone #: (________)_____________________________

Employer or School Name: ____

Address: ____

PERSON TO CONTACT IN CASE OF EMERGENCY: ______________________________________

Address: ____

Home Phone: (________)_______________________ Work Phone: (________)________________________

Relationship: _________________________________

(OVER)

FINANCIAL INFORMATION

Responsible Party: ______________________________Relationship:_______________________________

Address: ____

Home Phone: (________)_____________________ Work Phone: (________)_________________________

ALL CO-PAYMENTS, DEDUCTIBLES, CO-INSURANCE PAYMENTS & NON-COVERED SERVICES ARE DUE AT THE TIME OF YOUR SERVICE.

Financial Assignment and Agreement

Our practice is committed to providing you with the highest quality of patient care. The following is a statement of our financial policy which we require that you read and sign prior to any treatment being rendered. (Note: All patients must complete our "Patient Information Form" prior to seeing any physician in the practice.)

Cash Patients: If you do not have a valid insurance plan to cover the costs of our services you will need to make full payment at the time of service. We accept cash, checks, or credit cards. Other payment arrangements may be arranged with the billing department prior to treatment.

All Insurance:

1. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.
2. I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration, its agents, or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services.
3. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

This policy has become necessary because some health insurance companies are denying legitimate charges as a cost containment maneuver. We will continue to bill insurance for your convenience. If your health insurance has not paid in 30 (thirty) days, you are responsible for the full amount owed.

Medicare Patients: Please remember that your deductible must be met for each calendar year.

Private Insurance/Third Party Injury Patients: We will bill your insurance as a courtesy to you. We do, however, require full payment at the time of your service unless prior arrangements have been made. (Note: Your insurance policy is a contract between you and the insurance company. We are not a party to that contract. Therefore, you are completely responsible for the cost of your treatment.) You are responsible for your contracted portion of reimbursement or co-payment at the time of service. If your co-payment is not made at the time of service, an additional fee may be charged for administrative costs.

Missed Appointments: Due to our efforts to accommodate all patients when they need to be seen, we ask that if you are unable to keep your scheduled appointment that you cancel no later than 24 hours in advance. We understand that although circumstances at times may prevent doing this, after a second missed appointment we may add a $25.00 missed appointment charge to your account.

Minor Patients: The parents or legal guardians of minor patients have full financial responsibility.

Other Fees: In the event that you need copies of your medical records, a copy fee will be charged. Third party exams that require additional forms to be completed by the physician or staff may be subject to a $25.00 form fee.

We accept cash, checks, Visa, MasterCard, American Express, and Discover.

SIGNATURE OF ACKNOWLEDGMENT: I realize that I am responsible for payment of all medical services rendered to me and/or my dependents, regardless of the decision of reimbursement made by my insurance carrier. I have read the above and acknowledge that I am aware of the practice's Financial Policy. I authorize payment from my insurance carrier(s) for medical and/or surgical benefits to the treating physician. I further authorize my physician to release any and all information necessary concerning my diagnosis and treatment for the purpose of securing payment from my insurance carrier(s). I ACCEPT FULL FINANCIAL RESPONSIBILITY FOR ALL MEDICAL SERVICES PERFORMED ON MY BEHALF IF NOT COVERED FULLY BY INSURANCE.

NOTE: Your signature below will remain in effect unless written consent is received to revoke your authorization.

____

Signature **Date**

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Medical History Questionnaire

Name ____ Date ___________________

Date of Birth _________________________ Date of last eye exam _______________________

List any medications you currently take (prescription and over the counter):

____

____

Do you have any allergies to any medications? ☐ Yes ☐ No
If Yes, list the medications:

____

PAST HISTORY
List all **major** illnesses (glaucoma, diabetes, high blood pressure, etc.) or **injuries** (concussion, etc.):

____

____

List any **surgeries** you have had (cataract, tonsillectomy, appendectomy):

____

____

Do you **currently** have any problems in the following areas? Please answer every illness. If Yes, please provide information.

REVIEW OF SYSTEMS	Yes	No	Explanation of Problem
EYES (Glaucoma, cataract, retinal disease, etc.)			
Loss of vision			
Blurred vision			
Fluctuating vision			
Distorted vision (halos)			
Loss of side vision			
Double vision			
Dryness			
Mucous discharge			
Redness			
Sandy or gritty feeling			
Itching			
Burning			
Foreign body sensation			
Excess tearing/watering			
Glare/light sensitivity			
Eye pain or soreness			
Infection of eye or lid (blepharitis, stye)			
Tired eyes			
Crossed eyes, lazy eye			
Drooping eyelid			
GENERAL/CONSTITUTIONAL			
Fever			
Weight loss			
Other			

OVER

	Yes	No	Explanation of Problem
EARS, NOSE, THROAT (Sinus, ear infection, chronic cough, dry mouth, etc.			
CARDIOVASCULAR (Heart, vessels, etc.)			
RESPIRATORY (Asthma, emphysema, etc.)			
GASTROINTESTINAL (Stomach ulcers, intestinal disease, etc.)			
GENITAL, KIDNEY, BLADDER			
MUSCLES, BONES, JOINTS (Arthritis, etc.)			
SKIN (Acne, warts, skin cancer, etc.)			
NEUROLOGICAL (Multiple Sclerosis, etc.)			
PSYCHIATRIC (Anxiety, depression, insomnia, etc.)			
ENDOCRINE (Diabetes, hypothyroid, etc.)			
BLOOD/LYMPH (cholesterolemia, anemia, etc.)			
ALLERGIC/IMMUNOLOGIC (Hay fever, lupus, Sjogrens, etc.)			

FAMILY HISTORY M=mother F=father S=sibling GP=grandparent

DISEASE	Yes	No	Relationship to Patient
Blindness			
Glaucoma			
Arthritis			
Cancer			
Diabetes			
Heart disease or high blood pressure			
Kidney disease			
Lupus			
Stroke			
Thyroid disease			
Other			

SOCIAL HISTORY

Current occupation: ______________________________

Education (high school, vocational school, college degree): ______________________________

Marital Status (married, divorced, single, widowed): ______________________________

Living Arrangements: ______________________________

Do you drive? ☐ Yes ☐ No

Do you have visual difficulty when driving? ☐ Yes ☐ No

Do you have problems with night vision? ☐ Yes ☐ No

Have you ever tried to wear contact lenses? ☐ Yes ☐ No

Do you currently wear contact lenses? ☐ Yes ☐ No

If Yes, how long have you worn contact lenses? ______________________________

Do you currently wear glasses? ☐ Yes ☐ No

If Yes, how long have you had the current prescription? ______________________________

Have you ever had a blood transfusion? ☐ Yes ☐ No

History reviewed. ☐ No Changes ☐ Additions as noted above.

Physician's Signature: ______________________________ Date: ____________________

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Advanced Retina Associates, Inc.
Sanjay Logani, M.D.
Diplomate, American Board of Ophthalmology

DISEASES & SURGERY OF THE RETINA & VITREOUS
DIABETIC RETINOPATHY & MACULAR DEGENERATION
UVEITIS & OCULAR ONCOLOGY

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INFORMED CONSENT FOR DILATING EYE DROPS

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye.

Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it's best if you make arrangements not to drive yourself.

I hereby authorize Dr. Sanjay Logani and/or such assistants as may be designated by him to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

____

Patient (or person authorized to sign for patient) Date

PHOTO RELEASE

I, ____ authorize the office of Sanjay Logani, M.D. to take photographs of my eyes. These photos will be kept in a chart bearing my name and will be kept and used with the utmost respect for my privacy. These photographs may be used for research and/or educational purposes.

____

Patient (or person authorized to sign for patient) Date

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