NORTH SUBURBAN EYE ASSOCIATES, P.C.

(PLEASE COMPLETE **ALL ITEMS** AND **PRINT**)

PATIENT INFORMATION

Name ______________________________ DOB ______________ Gender __________

Street Address ____________________ City ________________ State ____ Zip Code __________

Employer ______________________ Business Address ______________________________

Preferred Contact # ______________________ Second Preferred # ______________________

Email Address __________________________ ☐ Married ☐ Single ☐ Other __________

Primary Care Physician ____________________ Address ______________________________

Emergency Contact

Name ______________________________ Relationship ________________________

Address ____________________________ Telephone # ________________________

Has this office previously treated any member of your family? Yes ☐ No ☐ – If yes, whom______________

HEALTH INSURANCE

Medicare: Yes ☐ No ☐ #______________________________________

Medicaid: Yes ☐ No ☐ #______________________________________

Name of other health insurance: ________________ Policy # ________________Group#________

Subscriber Name: ______________________ Relationship to Patient: ______________________

Are you here due to an injury? ☐ Yes ☐ No If yes, where did the injury occur?__________________

Motor Vehicle Accident ☐ At Work ☐ At Home ☐ Other ______________________________

1.) Under the ACA the Federal Government is requiring us to ask our patient to report the following demographic information:

Please identify your race:

- ___White
- ___American Indian
- ___Alaska Native
- ___Asian
- ___Other Pacific Islander
- ___Native Hawaiian
- ___Black or African American
- ___More than one race
- ___Undefined
- ___ Refused to Report/Unreported

Please identify your ethnicity:

- ___Non-Hispanic or Latino
- ___Hispanic or Latino
- ___Undefined
- ___Refused to Report/Unreported

Preferred Language:

___ Arabic	___ Italian	___ Somali
___ Bulgarian	___ Japanese	___ Swahili
___ Chinese	___ Korean	___ Urdu
___ English	___ Polish	___ Hindi
___ French	___ Portuguese	
___ German	___ Russian	
___ Hebrew	___ Central Khmer	
___ Spanish or Castilian		
___ Thai	___ Haitian or Creole	
___ Other or Not Reported		

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2.) In addition, under the HITECH changes to HIPAA you can elect to be contacted about appointment reminders and the need for an appointment by either of the following methods:

____ I wish to be called at the following number:____

____ I wish to receive an e-mail at the following address:____

FINANCIAL RESPONSIBILITY

Bill will be paid by: Patient ☐ Spouse ☐ Father ☐ Mother ☐ Workman's Comp ☐ Other ☐

If other party is financially responsible, list name and address:____

AUTHORIZATION FOR TREATMENT AND PAYMENT

I hereby consent to my examination and treatment in the office of North Suburban Eye Associates PC. In addition, I consent to the photography of my eyes for medical purposes. I authorize the doctor to obtain from other hospitals and physicians, records of my medical treatment. I understand that treatment for my medical condition is strictly between the doctor and myself. I understand that the doctor's office will assist me in filling out insurance forms, and that if the insurance company does not pay, for any reason, I am responsible for payment of the bill. In addition, I understand that I am responsible for any balance of the bill that the insurance company does not pay.

If I am insured by Medicare, I understand that Medicare does not pay for "non-covered" and "not medically necessary services" and that I am responsible to pay for these services. Specifically, Medicare considers refraction (measurement for glasses prescription) a "non-covered" service and I will be responsible for payment.

I authorize the release of any medical information necessary to process insurance claims for services rendered to me and request payments of insurance benefits for services rendered to be paid directly to North Suburban Eye Associates, P.C. I also certify that a copy of the practice's Notice of Privacy Practices has been made available to me.

3.) Please sign· and date below to acknowledge receipt of this notice.

____________________________ ____________________ ______________

PatientName/ Signature Patient DOB Date

AND (if not being signed by patient)

____________________________ ____________________ ______________

Signature of Responsible Party Relationship to. PT. Date

NORTH SUBURBAN EYE ASSOCIATES

PATIENT AUTHORIZATION

ASSIGNMENT OF BENEFITS

PRIMARY PAYER

I request that payment of authorized Medicare, Medicaid, or commercial plan benefits be made on my behalf to **North Suburban Eye Associates** for any service furnished to me by a physician of the group. I authorize any holder of medical information about me to release to the Centers For Medicare & Medicaid Services (CMS) and its agents or other insurance any information needed to determine these benefits payable for related services. In Medicare assigned cases, the provider agrees to accept the charge determination of the Medicare contractor, and I am responsible for the Medicare deductible, co-insurance or the 20% Medicare does not pay, and for any non-covered services.

SECONDARY INSURANCE OR MEDIGAP

I also request that the payment of authorized Medigap benefits or other secondary insurance be made either by me or on my behalf to **North Suburban Eye Associates**, or any physician of that group, for services provided to me by a physician of the group. I authorize any holder of medical information about me to release it to my Medigap insurer any information needed to determine these benefits payable for related services. I understand I am responsible for any deductible, co-pay, co-insurance and/or any non-covered procedures.

This assignment shall remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original.

My signature below further verifies that I have not joined an HMO or other entity in which my Medicare benefits have been relinquished.

PATIENT NAME: ____ **DOB:**________________

SIGNATURE: ____

DATE: ____

PATIENT HISTORY FORM

Date: ___/___/___

Name: ______________________________ D.O.B. ___/___/___ Gender: M / F

Referring Physician: ___________________ Primary Care Physician: _____________________

Optometrist: _________________________ Describe what brings you here today: ___________

____

Review of Systems: (List past and present information)

Do you currently have any of the following conditions?	Yes	No	If Yes, Please explain
Chronic fever, unexpected weight loss/gain, fatigue	☐	☐	______________________
Ear/nose/throat problems (e.g., hearing loss, sinus problems, sore throat)	☐	☐	______________________
Heart problems (e.g., chest pain, irregular heartbeat)	☐	☐	______________________
Respiratory problems (e.g., shortness of breath, wheezing, coughing)	☐	☐	______________________
Gastrointestinal problems (e.g., heartburn, abdominal pain, diarrhea, vomiting)	☐	☐	______________________
Urinary problems (e.g., pain or discomfort, blood in urine)	☐	☐	______________________
Skin problems (e.g., rashes, excessive dryness)	☐	☐	______________________
Musculoskeletal problems (e.g., muscle aches, joint pain, swollen joints)	☐	☐	______________________
Neurologic problems (e.g., numbness, weakness, headaches, paralysis)	☐	☐	______________________
Psychiatric problems (e.g., depression, anxiety)	☐	☐	______________________

List below Surgeries, Injuries, Illnesses and/or Conditions you are or have been treated for:

(Not previously listed above)

			Type	Date
Surgeries:	No ☐	Yes ☐	______________________	__________
			______________________	__________
			______________________	__________
Illnesses/Conditions:	No ☐	Yes ☐	______________________	__________
			______________________	__________
			______________________	__________
			______________________	__________
			______________________	__________
Injuries:	No ☐	Yes ☐	______________________	__________

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PATIENT HISTORY FORM

Ocular (EYE) History: (List past and present information)

		Type	Date
Surgeries:	No ☐ Yes ☐	______________________________	__________
		______________________________	__________
Injuries:	No ☐ Yes ☐	______________________________	__________
		______________________________	__________
Illnesses/Conditions:	No ☐ Yes ☐	______________________________	__________
		______________________________	__________
Medications:	No ☐ Yes ☐	______________________________	__________
		______________________________	__________

Please list all current medications:

______________________________________ ______________________________________
______________________________________ ______________________________________
______________________________________ ______________________________________
______________________________________ ______________________________________
______________________________________ ______________________________________

Please list any allergies (including latex):

______________________________________ ______________________________________
______________________________________ ______________________________________

Please list any Family History of:		Relationship to Patient
Diabetes	No ☐ Yes ☐	______________________________
Glaucoma	No ☐ Yes ☐	______________________________
Retinal Detachment	No ☐ Yes ☐	______________________________
Macular Degeneration	No ☐ Yes ☐	______________________________

Please complete the questions below regarding Social History:

Do you drink alcohol? No ☐ Yes ☐ How Much? __________________________

Do you smoke? No ☐ Yes ☐ How Much? __________________________

Place of Birth: City: ______________________ State: _____ Country: ________