NEW PATIENT INFORMATION

PLEASE PRINT CLEARLY

NAME:_____ SEX: M F MARTIAL STATUS: S M W D

SOCIAL SECURITY # _____-_____-_____ BIRTHDATE _____/_____/_____ AGE:_____

ADDRESS:_____ HOME PHONE: _____-_____

CITY:_____ STATE:_____ ZIP:_____ OTHER PHONE: _____-_____

EMAIL ADDRESS _____

EMPLOYER:_____ PHONE: _____-_____

SEASONAL RESIDENTS PLEASE PUT NORTHERN ADDRESS:

ADDRESS:_____ PHONE_____-_____-_____

CITY:_____ STATE:_____ ZIP:_____ DATES THERE:_____

INSURANCE INFORMATION - (Please give card/s to receptionist for copying)

PRIMARY :_____
SECONDARY:_____

ID#_____
ID#_____

If the patient is a minor, please complete the following section:

RESPONSIBLE PARTY:_____
PHONE:_____-_____

SS# _____-_____-_____ BIRTHDAY _____/_____/_____ RELATION:_____

REASON FOR TODAY'S VISIT

YEARLY EXAM If so, Date of last examination:_____/_____/_____

WORKER'S COMP If so, Date of Injury _____/_____/_____

Employer: _____
Phone:_____-_____

WC Insurance Carrier: _____
Phone:_____-_____

PROBLEM If so, please state what the problem is:_____

HOW DID YOU HEAR ABOUT US?

MY PHYSCIAN	FULL NAME:
MY INSURANCE COMPANY PROVIDER	NAME:
THE YELLOW PAGES	SPECIFY AD:
A FRIEND OR FAMILY MEMBER	NAME:

INTERNET
THE PRACTICE WEBSITE
SEMINAR DATE/LOCATION:
PRINTED AD SPECIFY:
OTHER

Primary Care Physician: _____ Phone: _____-_____

Referring Physician: _____ Phone: _____-_____

SOMEONE TO CONTACT IN CASE OF AN EMERGENCY

NAME:_____ PHONE:_____-_____ RELATION:_____

PLEASE READ FINANCIAL TERMS CAREFULLY…

If you do not have insurance or proof of your current insurance, payment is expected at the time services are rendered. We will NOT attempt to locate insurance information for you. All co-payments are collected at the time service is rendered as well.

Financial Agreement/ Medical Release – We accept Medicare Assignment. This means that we accept the approved amount Medicare determines. The patient is responsible for the yearly deductible and the 20% Medicare Part B co-insurance. As a courtesy we will bill the patient's secondary insurance. Patient will be responsible to pay the co-insurance if they do not have a secondary insurance. Please note that after 60 days from billing if your secondary insurance has not paid, you will be responsible to pay.

We participate with most Commercial Insurance (ex: Blue Cross/ Blue Shield, Aetna, United Healthcare). Check your provider directory if you are unsure. Patient is responsible for their deductibles, co-pays, and co-insurance. When the insurance has processed your claim they will send you an Explanation of Benefits, which explains the amount that you are responsible for. Patient payment is required within 30 days of the insurance payment. Patient is responsible for co-pay at the time services are rendered.

*** Worker's Compensation cases need an authorization BEFORE services are rendered.**

*** Self – Pay accounts must be paid at the time services are rendered**, unless other arrangements have been made with our billing department.

NOTICE OF PRIVACY PRACTICES – By signing below, you are agreeing that you have read and understood our notice of privacy practices. If you would like a copy, please ask our receptionist.

I understand I am responsible for all services rendered by Advanced Eye Care & Laser Center and/or Dr. Alina K. Stanciu. In the event my insurance carrier does not pay the claim(s) to satisfaction, I understand that it is my responsibility to pay for all non-covered services. I hereby authorize any insurance benefits to be paid directly to the physician providing services. I also authorize the release of any medical information necessary to process an insurance claim.

_____ _____/_____/_____

Signature of Patient (or Legal Guardian if Patient is Minor) Date

Release of Medical Information/ OPTIONAL

I give permission to the employees of Advanced Eye Care & Laser Center to release medical information to the following family members.

NAME:_____ RELATION:_____

NAME:_____ RELATION:_____

_____ _____/_____/_____

Patient Signature Date

HEALTH QUESTIONNAIRE

1. ARE YOU **CURRENTLY** HAVING ANY OF THE FOLLOWING EYE PROBLEMS?
   ____Pain
   ____Itching
   ____Redness
   ____Tearing or Discharge
   ____Blurred or Fuzzy Vision
   ____Glare
   ____Problem with Glasses or Contacts

2. HAVE YOU EVER HAD ANY OF THE FOLLOWING EYE PROBLEMS **IN THE PAST**?
   ____Glaucoma
   ____Cataracts
   ____Retinal Problems
   ____Eye Injury explain:_____
   ____Infections explain:_____
   ____Spots
   ____Halos

3. DO YOU WEAR GLASSES? NO YES, if yes for what: reading distance bifocal

4. DO YOU WEAR CONTACTS? NO YES, if yes what type:_____

5. DO **YOU** HAVE ANY OF THE FOLLOWING HEALTH PROBLEMS?
   ____Diabetes
   ____High Blood Pressure
   ____Thyroid Trouble
   ____Allergies explain:_____
   ____Asthma
   ____Headaches
   ____Sinus Infections
   ____Other _____

6. ARE ANY OF THE FOLLOWING CONDITIONS IN YOUR **FAMILY HISTORY**?
   ____Glaucoma
   ____Blindness
   ____Retinal Problems
   ____High Blood Pressure
   ____Crossed Eyes
   ____Other _____

7. ARE YOU **ALLERGIC** TO ANY MEDICATIONS: NO YES, specify_____

8. HAVE YOU EVER HAD EYE SURGERY: NO YES, specify_____

9. WHEN WAS YOUR LAST EYE EXAM? _____WITH WHOM? _____

10. LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:_____

    _____