PENINSULA
EYE
CENTER
Professional Association

MEDICAL HISTORY

Please fill out completely. Check yes or no for each question.

DATE	NAME		
SOCIAL SECURITY # ☐☐☐–☐☐–☐☐☐☐	AGE	☐ MALE	☐ FEMALE

REASON FOR VISIT

PROB FOCUS

EXPANDED

DETAILED

COMPREHENSIVE

EYE/ENT SYSTEM REVIEW

EYE PAIN	☐ YES	☐ NO
LIGHT FLASHES	☐ YES	☐ NO
STRAIGHT LINES APPEAR CROOKED	☐ YES	☐ NO
BLURRED VISION	☐ YES	☐ NO
ITCHY/WATERY EYES	☐ YES	☐ NO
DIFFICULTY WITH NIGHT VISION	☐ YES	☐ NO
DOUBLE VISION	☐ YES	☐ NO
GLARE/LIGHT SENSITIVE	☐ YES	☐ NO
DRY EYES	☐ YES	☐ NO
SINUS/NASAL CONGESTION	☐ YES	☐ NO
DRY THROAT	☐ YES	☐ NO
OTHER:		☐ NO

ORGAN SYSTEM REVIEW

HEART TROUBLE/CHEST PAIN	☐ YES	☐ NO
HIGH BLOOD PRESSURE	☐ YES	☐ NO
HIGH CHOLESTEROL	☐ YES	☐ NO
DIABETES	☐ YES	☐ NO
THYROID	☐ YES	☐ NO
LUNG DISEASE/ASTHMA/SHORT OF BREATH	☐ YES	☐ NO
CANCER	☐ YES	☐ NO
BLEEDING PROBLEMS/ANEMIA	☐ YES	☐ NO
ARTHRITIS	☐ YES	☐ NO
STROKE	☐ YES	☐ NO
NEUROLOGIC DISORDERS	☐ YES	☐ NO
HEADACHES/MIGRAINES	☐ YES	☐ NO
SKIN DISORDERS/PSORIASIS	☐ YES	☐ NO
INTESTINAL/COLITIS	☐ YES	☐ NO
FEVER/WEIGHT LOSS/SWEATS	☐ YES	☐ NO
MEMORY LOSS/DEPRESSION	☐ YES	☐ NO
KIDNEY DISEASE/STONES/BLADDER	☐ YES	☐ NO
AIDS/EXPOSURE	☐ YES	☐ NO
HISTORY OF TUBERCULOSIS	☐ YES	☐ NO
HEPATITIS/YELLOW JAUNDICE	☐ YES	☐ NO

ALLERGIES/SPECIFIC REACTIONS: ☐ Check if none.
List:

PREVIOUS EYE SURGERY & DATE: ☐ Check if none.
List:

PRESENT EYEDROPS AND DOSAGE: ☐ Check if none.
List:

PREVIOUS SURGERY & DATE ☐ Check if none

NAME OF FAMILY DOCTOR:

PRESENT MEDICATIONS AND DOSAGE: ☐ Check if none.

HERBAL MEDICATIONS:

DIETARY SUPPLEMENTS:

ARE YOU PREGNANT ☐ YES ☐ NO

MEDICAL PROBLEMS: ☐ Check if none.

FAMILY HISTORY

			RELATIONSHIP
HEART TROUBLE	☐ YES	☐ NO	
HIGH BLOOD PRESSURE	☐ YES	☐ NO	
DIABETES	☐ YES	☐ NO	
LUNG DISEASE/ASTHMA	☐ YES	☐ NO	
KIDNEY DISEASE	☐ YES	☐ NO	
CANCER	☐ YES	☐ NO	
MIGRAINES	☐ YES	☐ NO	
GLAUCOMA	☐ YES	☐ NO	
MACULAR DEGENERATION	☐ YES	☐ NO	
DETACHED RETINA	☐ YES	☐ NO	
RETINITIS PIGMENTOSA	☐ YES	☐ NO	
CATARACT	☐ YES	☐ NO	
LAZY EYE	☐ YES	☐ NO	
CROSSED EYES	☐ YES	☐ NO	

SOCIAL HISTORY:

SMOKE	☐ YES	☐ NO
ALCOHOL USE	☐ YES	☐ NO
DO YOU DRIVE?	☐ YES	☐ NO
DO YOU USE A COMPUTER AT WORK?	☐ YES	☐ NO

OCCUPATION:

(Rev. 08/06)

Thank you for answering every question on this form.

PENINSULA EYE CENTER, P. A.

DATE: _____ ***PLEASE PRINT*** ACCOUNT #: _____

PATIENT'S NAME: _____ SSN: _____
(FIRST) (MIDDLE INITIAL) (LAST)

HOME ADDRESS: _____
(STREET) (CITY) (STATE) (ZIPCODE)

MAILING ADDRESS: _____
(IF DIFFERENT FROM ABOVE)

DATE OF BIRTH: _____ SEX: M F MARITAL STATUS: S M D W SEP

HOME PHONE: _____ CELL PHONE: _____

PRIMARY CARE PHYSICIAN: _____ PHARMACY: _____

PERSON TO NOTIFY IN CASE OF EMERGENCY- NAME, RELATIONSHIP & PHONE #:

_____

PRESENT EMPLOYER: _____ WORK PHONE #: _____
OCCUPATION

PARENT'S NAME (IF MINOR): _____

We are requesting your email address. By sharing your email address you will receive a personal email inviting you to view your medical record in our office portal.

- You will be able to view a summary of your Medical Record
- You may receive pertinent Patient Education Material regarding your eye history
- You will be able to Secure Message us to ask questions or request a prescription refill

Please choose one:

_____ I agree to provide my email address and prefer to be contacted in this manner when necessary.

Email address: _____

_____ I decline to provide my email address at this time OR _____ I do not have an email address

SIGNED: **X**_____ DATE: _____

INSURANCE AUTHORIZATION:

I hereby authorize my insurance carrier to pay the proceeds of any benefits due directly to: Peninsula Eye Center, P.A. and the release of any medical information necessary to process insurance claims.

SIGNED: **X**_____ DATE: _____

PLEASE SIGN AT BOTH X's

OFFICE FINANCIAL POLICY & AGREEMENT

Our office is dedicated to providing the best possible care to our patients. The following policies were developed to prevent any misunderstandings about our financial and payment procedures. If you have any questions about this, please feel free to discuss them with our office manager.

* **Payment for non-covered services, deductible and co-insurance amounts is expected at the time of service or upon receipt of a statement from our office. If your insurance has a co-pay, this amount will be collected at the time of service.** For your convenience, we accept cash, personal checks, MasterCard, Visa, American Express and Discover.

* Self pay patients must pay for services in full at time of service unless prior arrangements have been made with the Office Manager.

* Our office participates with most insurances carriers as well as Medicare. **If we do not participate with your insurance carrier, payment in full is expected at the time of service.** We will provide you with a receipt that will contain all of the information needed from this office for your insurance company to process your claim.

* In cases where a liability action is involved, payment for the service is the responsibility of the patient who has received treatment, not the individual who is being sued. For this reason and the fact that lawsuits can go on for an extended period, we feel that our bill should be paid promptly.

* For services rendered to minor patients, the parent or legal guardian requesting the services will be responsible for payment, regardless of any legal binding agreement in the case of custody arrangements.

* If a HMO insures you, you must contact your insurance company or primary care physician for the appropriate authorization and/or referral prior to being seen. If this has not been done you will be required to sign a "Referral Release" acknowledging that you will be **responsible for payment** if you are seen.

COLLECTION POLICY & AGREEMENT

I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical services provided, when a statement is rendered. Accounts that have not been paid or made payment arrangements within a reasonable amount of time will be referred to our collection agency. **The collection agency fee of 35%, attorney fee and 2% monthly interest will be the responsibility of the patient and/or guarantor**. If court action is necessary to enforce payment hereunder, the venue for any such court action shall be Wicomico County, Maryland unless provider elects otherwise.

_____ _____

Signature of Patient/Legal Guardian Date

_____

Patient Name (Please Print)

Peninsula Eye Center, P.A. / Peninsula Cataract & Laser Center

Brandon M. Metcalf, M.D., M.P.H.
Raymond J. Clifford, M.D.
Edmund J. Forte, M.D.*
David J. Ospital, M.D.*
Kevin W. Darcey, O.D.

*Diplomates of the American Board of Ophthalmology

The Joint Commission
National Quality Approval

NOTICE
TO ALL PATIENTS

With the increasing complexity of insurance billing, we are faced with claims being denied due to several problems. We have received a significant number of phone calls from patients asking us to change diagnosis for their denied claims, specifically from routine care to medical problem or vice versa. This is considered insurance fraud and the practice will not be a part of fraudulent activity. **We will not change a diagnosis after it has been submitted to your insurance company.** We cannot be expected to know the insurance coverage of every patient and we do not base our diagnosis on the patient's insurance coverage.

To prevent erroneous denials and to help you collect from your insurance on the first filing of the claim, Please clearly indicate on your Medical History form if you are coming for a routine eye exam (vision coverage) or for a specific medical problem (medical coverage). If you have a concern regarding the doctor's diagnosis, please verify it upon checkout after your visit.

If you are using Routine Insurance and the physician finds a medical diagnosis, your Medical Insurance will be billed and you may have an out of pocket expense.

Patient's Name: _____ Patient's Signature: _____

FEE FOR REFRACTION

Refraction is a necessary part of an ophthalmic examination. Refraction is the optical determination of the best possible eye vision. The exam indicates if any optical treatment instead of medical or surgical treatment is necessary. Most major insurance companies do **not cover** charges for refraction. Medicare is one company that does not pay for this service. The fee for refraction is $35.00. The amount is to be paid in full at the completion of your visit.

Thank you for your cooperation.

Patient's Name: _____ Patient's Signature: _____

101 Milford Street
Salisbury, MD 21804
(410) 749-9290 • (800) 210-5936
Fax (410) 543-9087

314 Franklin Avenue
Berlin, MD 21811
(410) 641-3955
Fax (410) 641-9041

500 Market Street
Pocomoke, MD 21851
(410) 957-1355
Fax (410) 957-2191

1320 Middleford Road
Seaford, DE 19973
(302) 629-3044
Fax (302) 629-3206

TTY Users Call Maryland Relay #711

www.peninsulaeyecenter.net

Peninsula Eye Center, P.A. / Peninsula Cataract & Laser Center

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PATIENT NAME:_____

ACCOUNT #:_____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

1. **By signing below, I am acknowledging that I am aware that Peninsula Eye Center's "Notice of Privacy Practices" are accessible in all patient areas.**

2. **I am also aware that there is written information detailing my operating physician's credentials included with the Notice.**

☐ **I give my permission to discuss my health records and test results with:**
(List Name(s) and Relationship)_____

☐ **I <u>do not</u> give my permission to discuss my health records and test results with anyone other than myself.**

_____ Date:_____
Signature (Patient or Authorized Representative)

_____
Printed Name (Patient or Authorized Representative)

Revised 7/2014