Please bring forms with you to your visit along with all insurance cards and a list of all current medications include vitamins. Thank you.

Medical Information : Many health conditions affect the eyes

1. Do you have any of the following conditions:

Seasonal allergies	Y	Dry mouth (Head)	Y	Psychological Disease (Psy)	Y
Vascular Disease (Ca)	Y	Headaches – frequent (Head)	Y	Asthma (Rep)	Y
High Cholesterol (Ca)	Y	Migraines (Head)	Y	COPD (Rep)	Y
High Blood Pressure (Ca)	Y	Hearing loss (Head)	Y	Emphysema (Rep)	Y
Stroke (Ca)	Y	Sinus problems (Head)	Y	Cancer type:_____	
Heart Trouble (Ca)	Y	Anemia (HE)	Y	Other: _____	
Heart surgery (Ca)	Y	Bleeding problems (IN)	Y	_____	
Fatigue (Co)	Y	Autoimmune Disease (IN)	Y		
Sleep Apnea (Co)	Y	Acne (IN)	Y	**Eye problems**	
Weight (Co) loss or gain		Rosacea (IN)	Y	Lazy eye RT or LT	Y
Diabetes – Type 1 (E)	Y	Psoriasis (IN)	Y	Color blindness	Y
Diabetes – Type 2 (E)	Y	Skin Cancer	Y	Blindness	Y
Diabetic Suspect (E)	Y	Osteoarthritis (Mus)	Y	Cataracts	Y
Thyroid – overactive (E)	Y	Rheumatoid Arthritis (Mus)	Y	Glaucoma	Y
Thyroid – underactive (E)	Y	Joint pain (Mus)	Y	Macular degeneration	Y
Acid Reflux (Ga)	Y	Multiple Sclerosis (Ne)	Y	Dry Eyes	Y
GI problems (Ga)	Y	Seizure (Ne)	Y	Flashes new or old	Y
Kidney problems (Ge)	Y	ADD or ADHD (Psy)	Y	Floaters new or old	Y
Prostate (Ge)	Y	Alzheimer's (Psy)	Y	Eye injury	Y
Pregnant (Ge)	Y	Anxiety (Psy)	Y	Eye Surgery	Y
Nursing (Ge)	Y	Depression (Psy)	Y	Other: _____	

2. Please list all current medications or provide complete list: _____

_____

_____

_____

3. Primary Care Physician: _____

4. Do you drink alcohol? No Social Daily Other _____

5. Do you smoke? Yes # of years _____ No Former Smokeless tobacco

6. Family history

						Grandmother	**Grandfather**
Diabetes -	**None**	Father	Mother	Sister	Brother	*Maternal or Paternal*	*Maternal or Paternal*
High Blood Pressure	**None**	Father	Mother	Sister	Brother	*Maternal or Paternal*	*Maternal or Paternal*
Cataracts	**None**	Father	Mother	Sister	Brother	*Maternal or Paternal*	*Maternal or Paternal*
Glaucoma	**None**	Father	Mother	Sister	Brother	*Maternal or Paternal*	*Maternal or Paternal*
Macular degeneration	**None**	Father	Mother	Sister	Brother	*Maternal or Paternal*	*Maternal or Paternal*

Patient Name:_____ Today's date:_____

DRIVE BY YELLOW PAGES ADVERTISEMENT INSURANCE FRIEND DOCTOR OTHER

PT PREFERRED NAME OR NICKNAME:_____

PREFERRED COMMUNICATION: Telephone Cell Email Postal Text

DAYTIME # :_____**CELL #**_____

E-MAIL ADDRESS :_____

Name and Address:

_____

_____

_____

Date of Birth _____

Insurance ID #_____

MARITAL STATUS: Married Single Divorced Seperated Widowed **PREFERRED LANGUAGE:** English or Spanish

RACE\ETHNICITY: Caucasian\White Asian American Indian\Alaska Native Black\African American Hispanic\Latino Hawaiian\Other Pacific Island

EMPLOYMENT: FT or PT **Place of Employment \ Occupation**:_____ Unemployed Retired Military Student: FT or PT

X INSURANCE SUBCRIBER INFO: NAME:_____ RELATIONSHIP TO PT _____DATE OF BIRTH_____

ADDRESS, IF DIFFERENT FROM PT:_____

SIGNATURE ON FILE\FINANCIAL RESPONSIBILTY

I authorize use of this form on **all** insurance submissions. I **authorize** release of information to **all insurance companies**.

I authorize the doctor to act as **my** agent in helping to obtain payment from the insurance companies.

I authorize payment **direct** to the doctor. **I permit** a **copy** of this authorization to be used in place of the original.

I understand that I am responsible for any bills incurred.

I understand that **I am responsible** for any items not covered by insurance or over insurance allowances, items may include **refraction, eyewear (frame and lens), contacts, retinal photography.**

I understand that **I am responsible** for 1 ½ % interest monthly, Attorney's fees, and collection costs on any unpaid balances.

X Signature: _____ Date: ___/___/___ Relationship: Self Parent Other

ACKNOWKEDGEMENT OF RECEIPT AND GENERAL CONSENT

I acknowledge that I viewed a copy of Michael J. Dolan, O.D,'s Notice of Privacy Practices.

I further consent to the release of my health information for purposes of treatment, payment, and health care operations and as authorized or required by law under the circumstances described in the notice of Privacy Practices.

X Signature: _____ Date: ___/___/___ Relationship: Self Parent Other

ADVANCED BENFICIARY NOTICE OF NONCOVERAGE (MEDICARE PARTICIPANTS)

IF MEDICARE DOESN'T PAY FOR THE FOLLOWING, YOU MAY HAVE TO PAY. MEDICARE DOES NOT PAY FOR EVERYTHING, EVEN SOME CARE THAT YOU OR YOUR HEALTH CARE PROVIDER HAVE GOOD REASON TO THINK YOU NEED. WE EXPECT MEDICARE MAY NOT PAY FOR THE FOLLOWING.

NON COVERED ITEMS ** **REFRACTION** (DETERMINES YOUR PRESCRIPTION FOR GLASSES)

** **EYEWEAR OR CONTACTS** NOT RELATED TO POST CATARACT SURGERY **PHOTOGRAPH** RETINAL SCREENING

** **FRAME AND LENS** OPTIONS OVER AND ABOVE BASIC FRAME, SINGLE VISION or LINED BI-FOCAL LENSES RELATED TO POST CATARACT SURGERY

__1. I WANT THE ITEMS LISTED ABOVE. YOU MAY ASK TO BE PAID NOW, BUT I ALSO WANT MEDICARE BILLED FOR AN OFFICIAL DECISION ON PAYMENT, WHICH IS SENT TO ME ON MSN. I UNDERSTAND THAT IF MEDICARE DOESN'T PAY, I AM RESPONSIBLE FOR PAYMENT, BUT I CAN APPEAL TO MEDICARE BY FOLLOWING THE DIRECTIONS ON THE MSN. IF MEDICARE DOES PAY, YOU WILL REFUND ANY PAYMENTS I MADE TO YOU, LESS CO-PAYS OR DEDUCTIBLES.

__2. I WANT THE LISTED ABOVE, BUT DO NOT BILL MEDICARE. YOU MAY ASK TO BE PAID NOW AS I AM RESPONSIBLE FOR PAYMENT. I CANNOT APPEAL IF MEDICARE IS NOT BILLED.

__3. I DON'T WANT THE LISTED ABOVE. I UNDERSTAND WITH THIS CHOICE I AM NOT RESPONSIBLE FOR PAYMENT, AND I CANNOT APPEAL TO SEE IF MEDICARE WOULD PAY.

X