Ophthalmology Associates of the Valley
Returning Patient History Questionnaire

Patient's Name _____ **Today's Date**_____

Primary Care Physician _____

Medication Allergies: (Please List Drug and Reaction):

_____

_____

Reason for today's visit (Are you currently experiencing any of the following symptoms?):
No☐ Routine exam, no particular symptoms (Your insurance may not cover routine exams)
Yes (please circle below)
eye pain burning, itching or scratching sensation redness tearing discharge
blurred or fuzzy vision double vision problems with glasses flashing lights
cobwebs, dark spots or dark veils headache
other_____

Eye History: Have you had any NEW eye problems, injuries, or surgeries since the last visit?
☐ No ☐ Yes (if yes, give details)

_____

_____

_____

Medical History: Have there been any NEW major illnesses, hospitalizations, injuries?
☐ No ☐ Yes (if yes, give details)

_____

operations or surgeries ☐ No☐ Yes (if yes, give details)

_____

Current Medications:☐ None (if currently taking a medication, list the drug, reason for taking and dose)
Drug _____ Reason _____ Dose _____
Drug _____ Reason _____ Dose _____
Drug _____ Reason _____ Dose _____

Family History:
Have there been any NEW eye problems in the family?☐ No☐ Yes (if yes, give details)

_____

_____

Review of Systems: (Are you currently experiencing any of the following symptoms?)
Chronic fever, fatigue, weight loss ☐ No☐ Yes _____
Ears, Nose, Throat Problems ☐No☐Yes_____
Allergies (food, environmental) ☐No☐Yes_____
Cardiovascular (blood pressure, pulse) ☐ No☐Yes_____
Respiratory (asthma, cough) ☐No☐Yes _____
Gastrointestinal (nausea, vomiting, bowel problems) ☐No☐ Yes_____
Kidney, Bladder, Genital Problems ☐No ☐Yes_____
Muscles, Joints, Bones (arthritis, pains) ☐ No☐Yes_____
Skin (rashes, moles) ☐ No☐Yes_____
Neurological (headache, weakness, habits) ☐No ☐Yes_____
Psychiatric (anxiety, depression, insomnia) ☐No ☐ Yes_____
Endocrine (diabetes, thyroid) ☐No ☐Yes _____
Blood (anemia, bleeding problem) ☐No☐Yes_____

History Questionnaire Completed By: _____(signature)
For Office Use Only:
History Reviewed: _____ _____
Staff Signature Date

Ophthalmology Associates of the Valley

PATIENT REGISTRATION FORM

Mr. Mrs. Miss Ms_____ Today's Date:_____

Address:_____

City:_____ State:_____ Zip:_____

Your Home Phone:_____ Your Work Phone:_____

Your Cell Phone:_____

Name of employer:_____ Occupation:_____

Sex: M F Marital Status: ❑ Single ❑ Divorced ❑ Married ❑ Widowed

Social Security Number: ___-___-___ Date of Birth:__/__/__ Age:_____

Drivers License #_____ Exp. Date _____

E-mail:_____

❑ I would like to receive information regarding appointments, health & eye disorders, updates on our practice, services, specials or monthly newsletters by email (you can unsubscribe at anytime).

Patient Spouse:_____ Spouse Work Phone:_____

If Patient is a minor, Please provide name of Parent/Guardian: _____ Phone: _____

Referred by:_____ Phone: _____

❑ Doctor ❑ Optometrist ❑ Existing Patient ❑ Family Member ❑ Co-Worker ❑ Friend
❑ Yellow Pages ❑ Internet ❑ Other

Family Physician:_____ Phone: _____

Emergency Contact Name_____ Phone: _____

Government regulations contained in the Patient Protection Affordable Care Act have mandated that we collect the following additional demographic information.

1. Preferred Language:_____

2. Race (please check appropriate box below)

❑ American Indian or Alaskan Native ❑ Asian ❑ Black or African American

❑ White or Caucasian ❑ Native Hawaiian or other Pacific Islander ❑ Other Race ❑ Decline to answer

3. Ethnicity (please check appropriate box below)

❑ Not Hispanic or Latino ❑ Hispanic or Latino ❑ Unknown ❑ Decline to answer

(PLEASE COMPLETE REVERSE SIDE)

Ophthalmology Associates of the Valley

Insurance: Please list the subscriber of the policy if other than the patient. List your primary insurance company first.

PRIMARY HEALTH

1._____ Policy # _____

Subscriber Name: _____ Date of Birth:_____ ID#: _____

SECONDARY HEALTH

2._____ Policy # _____

Subscriber Name: _____ Date of Birth:_____ ID#: _____

VISION PLAN

3._____ Policy # _____

Subscriber Name: _____ Date of Birth:_____ ID#: _____

Please Read and Initial:

I authorize the release of any medical information necessary to process all claims.
____ Initial

I understand that I am responsible for payment of my account regardless of insurance coverage or eligibility.
____ Initial

I understand that I am responsible for payment on my account for any non-covered items.
____ Initial

I request that the payment of authorized insurance benefits be made on my behalf to **Ophthalmology Associates of the Valley, Peter D. Zeegen, M.D., David H. Aizuss, M.D., Brad S. Elkins, M.D., Stanley M. Kopelow, M.D., Stan Saulny, M.D., Mark H. Kramar, M.D.,** for services furnished to me by that supplier. I permit a copy of this authorization to be used in place of the original and authorize any holder of medical information about me to release to the Health Care Financing Administration or its agents any information to determine these benefits payable for related services.
____ Initial

REFRACTION SERVICE AND FEE

One of the most important parts of your eye exam today is the refraction. This is the part of the exam by which we determine whether you can be helped in any way by a new glasses prescription. It is also how we determine the best possible visual acuity and function of your eye, which is essential medical information for us to have as we assess your eyes and look for problems. It is NOT a covered service by Medicare and many other insurance plans. These plans consider refraction a “vision” service not a “medical” service. Our office fee for refraction is payable at the time of service in addition to any co-payment your plan may require. Should your plan pay us for the refraction, we will reimburse you accordingly.

I have completely read all the above information and agree to all the terms.

_____ _____

Signature of patient or person acting on patient’s behalf Date

Any information that we collect about you on this form will be kept confidential in our offices.

We're Giving your Prescription a "Head Start" Before you ever leave the office

Our practice can send prescriptions electronically to local pharmacies that are connected to the Pharmacy Health Information Exchange, Operated by SureScripts. Instead of a paper prescription, we can send the same information directly to the pharmacy computer.

That means a safer and more efficient prescribing process for you.

- **No More Lost Prescriptions**
- **No trip to the pharmacy to drop off the prescription**
- **No illegible handwriting for the pharmacist to interpret**

We Think you'll agree, it's a better way to fill your prescriptions.

In order to start we need to have your Pharmacy information;

Patient Name_____

Patient Home Zip Code_____

D.O.B. _____ M/F_____

PHARMACY Name _____

PHARMACY Address_____

PHARMACY City _____State____Zip code_____

PHARMACY Phone_____3-15-10

Peter D. Zeegen, M.D.,F.A.C.S.
David H. Aizuss, M.D.,F.A.C.S
Brad S. Elkins, M.D.,F.A.C.S.
Stanley M. Saulny M.D.,F.A.C.S.
Stanley M. Kopelow, M.D.
Mark H. Kramar, M.D. F.A.C.S

Ophthalmology Associates of the Valley (OAV) offers its patients the ability to communicate with us via electronic mail (e-mail) over the Internet.
If you have an Internet e-mail address and would like to take advantage of this service, please discuss your wishes with your doctor.
Some doctors prefer not to communicate with their patients over the Internet.
If we agree to exchange e-mail with you, please observe the following:

E-mails Rules:

1. E-mail may be used for requesting information and for asking non-urgent questions. It should not be used in emergencies. If you are experiencing a sudden or severe change in your health or otherwise need an immediate response, please call 911 or visit the nearest Emergency Department.
2. E-mail messages may not be confidential.
   - Do not use e-mail to send or request very sensitive information. OAV cannot and does not guarantee the confidentiality of any messages being sent over the Internet.
   - Messages can be misdirected or intercepted by unintended parties.
   - Patients who want e-mail sent to work addresses must recognize that employers may have the right to monitor their e-mail.
   - Your healthcare provider may ask a nurse or other provider to assist with email volume or response.
   - We will not respond to communications that are considered obscene or harassing.
3. Your healthcare provider will document e-mail communications in your medical record- either by placing a copy of the message in your record, or by summarizing the message in a written note.

Sending E-mail:

Please be sure to include the following information in the body of every e-mail message that you send to your healthcare provider:

- Your full name
- Your birth date, home addreess or your medical record number

If you do not provide this information, your healthcare provider may not to be able to respond. In order to protect your confidentiality do not place name, date of birth or medical record number in subject line.
If a message is ever returned because of a "bad address," please make sure that you entered the complete address as it was given to you. If you are sure that you entered the address that we provided, please call our office to verify you have the correct address and that the e-mail system is functioning properly.
If your healthcare provider does not answer your e-mail in what you consider to be reasonable period of time, please call our office. Your healthcare provider may be out of the office or we could be experiencing a technical problem and unable to respond to e-mail. We cannot guarantee a particular response time.
I agree to not use or forward my health care provider's e-mail for purposes other than communication with me about my health care.
I understand and agree to the terms outlined in this document. After reading the rules and guidelines of communicating via e-mail, I still wish e-mail to be one of my preferred methods of communication with my healthcare providers.

_____
Signature of Patient or Legal Representative

_____
Patient Name

_____
Email

_____
Date

Comprehensive Ophthalmology, Laser and Refractive Surgery, Cataract Surgery, Corneal Transplantation, Glaucoma and Glaucoma Surgery, Ophthalmic Plastic, Reconstructive, Lacrimal and Orbital Surgery, Diseases and Surgery of the Vitreous and Retina, Diabetic Retinopathy

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Ophthalmology Associates of the Valley

Financial Obligations & Assignment of Benefits

OAV doctors are participating doctors in most health plans; to continue to accept insurance plans we must collect all deductibles and co-pays due at the time of service. Since this amount may not be able to be determined today we ask for a credit card number so as to avoid the extra expense of billing you. If not we must ask for full payment today and then a refund in the appropriate amount will be made after your insurance generates an explanation of benefits

☐ **Co-pays and insurance deductibles are due at the time of service.**

☐ **As a courtesy, my insurance will be billed by Ophthalmology Associates of the Valley (OAV)**

☐ **A credit card is required to guarantee payment of co-pays, deductibles and co- insurances.**

☐ I assign benefits and hereby authorize my insurance carrier to pay OAV directly for services I receive from OAV.

☐ I will keep OAV up to date on my most current guarantor/health insurance information, my address, my phone number and other contact information so that claims can be processed correctly.

☐ I am responsible to ensure that my health insurance carrier honors claims submitted on my behalf by OAV for services rendered. If my carrier denies my claim I will promptly contact them to determine what additional information is needed to get the claim paid and provide them with any information they request from me.

☐ If I receive a check from my insurance for services provided by OAV, I agree to immediately endorse the back of the check to OAV.

We require a credit card to be on file for office visits, co-pays, deductibles, refraction, "non-covered" services, mail orders/products, procedure deposits, copy of medical records, phone consultations and after hour emergency services.

I, (please print name)_____, authorize Ophthalmology Associates of the Valley Medical Group to charge my credit card for the following reasons: routine vision services, charges that are "non covered" by my insurance, contact lens evaluation, co-pays, deductibles, refraction, mail orders/products, procedure deposits, copy of medical records, phone consultations and after hour emergency services.

_____ _____/_____/_____
Credit Card Number Expiration Date

_____ _____ _____
Security Code: Billing Street Number Billing Zip Code

_____ _____
Cardholder name Date

_____
Signature

_____
Patient name if different than cardholder

Comprehensive Ophthalmology, Laser and Refractive Surgery, Cataract Surgery, Corneal Transplantation, Glaucoma and Glaucoma Surgery, Ophthalmic Plastic, Reconstructive, Lacrimal and Orbital Surgery, Diseases and Surgery of the Vitreous and Retina, Diabetic Retinopathy