DELAWARE EYE SURGEONS, P.A.

2710 Centerville Road
Wilmington DE 19808

PLEASE PRINT CLEARLY

NAME: ______________________ BIRTHDATE: ______________ AGE: ________

ADDRESS: ______________________ SEX: ____ E-MAIL: ______________________

______________________ SS # ______________________

PHONE NUMBERS: Please list the order you want us to call you for any office business.

CELL #: ______________ **Choice #** HOME #: ______________ **Choice #**

EMPLOYER/OCCUPATION: ______________________ PHONE #: ______________ **Choice #**

EMERGENCY CONTACT : ______________________ PHONE #: ______________ **Choice #**

RACE: ____________ LANGUAGE: ____________ MARITAL STATUS: ____________

PRIMARY CARE DOCTOR: ______________________ PHONE #: ______________

PHARMACY NAME: ______________________ PHONE #: ______________

PHARMACY LOCATION: ______________________ REFERRED BY: ______________

INSURANCE INFORMATION – *Please fill in 1, 2 and 3 if your coverage is through a spouse or a parent.* ***Line 1 if self.***

1. PRIMARY INSURANCE: ______________ ID # ____________ GROUP # ____________
2. POLICY HOLDER: ______________ BIRTHDATE: ______________
3. SOCIAL SECURITY #: ______________ RELATION TO PATIENT: ______________

INSURANCE INFORMATION – *Please fill in 1, 2 and 3 if your coverage is through a spouse or a parent.* ***Line 1 if self.***

1. SECONDARY INSURANCE: ______________ ID # ____________ GROUP # ____________
2. POLICY HOLDER: ______________ BIRTHDATE: ______________
3. SOCIAL SECURITY #: ______________ RELATION TO PATIENT: ______________

I HEREBY AUTHORIZE RELEASE OF ANY MEDICAL INFORMATION AND THE FILING OF INSURANCE CLAIMS PERTAINING TO SERVICES RENDERED TO ME BY DELAWARE EYE SURGEONS, P.A.

I UNDERSTAND THAT THE REFRACTION PORTION OF ANY COMPLETE EYE EXAMINATION IS NOT COVERED FOR PAYMENT BY INSURANCE AND IS PAYABLE AT THE TIME OF SERVICE. IT IS FURTHER UNDERSTOOD THAT WITH CURRENT INSURANCE CUTS, CHARGES FOR SOME SERVICES MAY BE CLASSIFIED AS NON-COVERED BY MY PLAN, AND ARE MY FINANCIAL RESPONSIBILITY.

______________________ ______________________

PATIENT SIGNATURE DATE

PAST MEDICAL HISTORY

Name____Date_____________

OCULAR HISTORY

Please indicate if you have been diagnosed with any of the following:

_____ Cataracts
_____ Glaucoma
_____ Retinal detachment
_____ Macular degeneration

Please *indicate the RELATIONSHIP* of any immediate family members (Mother, father, brother sister even if deceased) who have been diagnosed with the following:

_____ Glaucoma | _____ Cataracts | _____ High blood pressure
_____ Retinal detachment | _____ Cancer | _____ Heart problems
_____ Macular degeneration | _____ Strabismus | _____ Diabetes

GENERAL MEDICAL HISTORY

Please indicate if you have been diagnosed with any of the following:

_____ Diabetes For how many years: ________________ A1C Level ___________
_____ Cancer - What type: ________________________
_____ Asthma
_____ Hypertension
_____ Arthritis
_____ Cholesterol
_____ Thyroid conditions
_____ Neurological conditions
_____ Ear, nose, throat conditions
_____ Heart disease
_____ Heart attack When: _____
_____ Shortness of breath
_____ Gastric intestinal conditions
_____ Urinary conditions
_____ Hepatitis/HIV
_____ Infectious disease
_____ Sleep apnea – Cpac machine Yes or No

Please list any other medical conditions:

____
____
____
____
____

SURGICAL HISTORY

Have you had eye surgery? Yes No (Circle one)
If yes, please supply the dates and procedures ______________________________
Have you had facial surgery? Yes No (Circle one)
If yes, please supply the dates and procedures ______________________________

MEDICATION HISTORY

Please fill out attached form OR if you have a written list we can make a copy.

Please list all medication allergies:______________________________________

Smoking History: Current _____________ Former_____________ Never_______________

Drinking History: Current _____________ Former_____________ Never_______________

Height _____________ Weight _______________ Blood pressure _______________

Name:______________________________________ Date:____________________

Dear Patient,

Here at the Delaware Eye Surgeons we take medication delivery very seriously. We believe that you are the key member of the team involved in your treatment. In order to provide the highest quality of care we would like for you to document the most accurate and complete list of the medications you are taking, including name, dose, and frequency of each medication. You may also inquire about a current list of medications from your primary care physician. Please feel free to contact us at (302)993-1300 with any questions.

Medication or Supplement	Amount Taken (Dose)	How Taken (Route)	How Often (Frequency)	When was the last dose taken
Example: Aspirin	*Example: 80 mg*	*Example: By Mouth*	*Example: Once a day*	*Example: 9pm 10/1/14*

FINANCIAL POLICY FOR DELAWARE EYE SURGERONS, P.A.

REFERRALS

If your insurance requires you to have a referral to see a specialist, you are required to have your referral prior to your visit. If the referral is NOT provided you will be asked to either reschedule or pay for the visit at the time of service.

CO-PAYS

The Patient is expected to present insurance card(s) at EACH visit. ALL co-payments and past due balances are due and payable at the time of service.

REFRACTIONS

Refractive services of routine eye exams are NOT covered by insurance. Routine eye exams are NOT covered by Medicare; therefore, they are NOT subject to the waiver of liability provision. Advance notification to the beneficiary is not required.

SELF PAY ACCOUNTS

Self-pay accounts are; Patients who are covered by insurance plans which the practice does not participate with, patients without insurance or if you deducible has not been met. Payment is required at the time of service for all services, including surgeries.

NONPARTICIPATING INSURANCE PLANS

The insurance company will be billed as a non-assigned claim as a courtesy to the patient with the patient's payment to the practice in full at the time of service. The insurance company may reimburse the patient or non-assigned claims. If the practice receives payment form the insurance company for a non-assigned claim, the patient will be refunded the amount paid.

AUTOMOBILE ACCIDENT CASES

The patient will be treated as a Self-pay account unless all information is received and verified through the insurance carrier.

PATIENT REFUNDS

The following criteria must be met prior to issuing a refund: There are no outstanding insurance claims on the patient's account and there are not outstanding balances on the account.

CHILD CUSTODY CASES

The parent with custodial custody is usually the parent who the child lives and usually accompanies the child to the practice for care. The custodial parent is responsible for payment at the time of service whether the account is considered self-pay, participating insurance, or nonparticipating insurance. If the non-custodial parent carries the child's insurance the practice will bill that insurance company. The practice does NOT get involved with divorce specifics, e.g., one parent pays 80% and the other pays 20%. It is the parent's obligation to work out an agreement between each other.

This financial policy helps the practice provide quality care to our valued patients. If you have any questions or need clarification on any of the above policies, please feel free to contact us.

Patient Signature:____________________________________ Date:____________________

S. Gregory Smith, M.D. & Associates

Cornea & Anterior Segment Surgery
Intraocular Lens Complications
Cataract & Refractive Surgery

Delaware Eye Surgeons. P.A.

2710 Centerville Road
Suite 102
Wilmington, Delaware 19808
302-993-1300
Fax 302-993-1400

662 North Dual Highway
Seaford, Delaware 19973
302-629-2333
Fax 302-629-8229

Health Insurance Portability and Accountability Act
Patient Privacy Right and Disclosure

Delaware Eye Surgeons, P.A. and its employee's disclose information given to us by the patient , the patient's insurance company, primary care physician, or other medical professionals for the purpose of treatment, payment of service rendered, or health care operations.

We **do not** sell to mailing lists or disclose personal information about our patients except that which is needed to carry out our objective, patient care.

Incompliance with HIPPA guidelines the patient understands that they have the right to review any information which is documented in the patient's record and the right to add an addendum to such records, if the record is disputed.

By signing this consent you agree to allow Delaware Eye Surgeons, P.A. to use and disclose personal information about you for the reasons above.

You have the right to revoke this consent at anytime, but be aware that we cannot guarantee care unless we can communicate with the other health professionals.

This consent becomes effective:
Today's Date________________

Patient Signature: ___________________________