

DELAWARE EYE SURGEONS, P.A.

2710 Centerville Rd. Suite 102

Wilmington, DE 19808

Name: _____ Birthdate: _____ Age: _____
Address: _____ Sex: _____ SS# _____

Email: _____
Marital Status: _____ Race: _____ Language: _____
Cell Phone: _____ Home Phone: _____
Emergency Contact: _____ Relation _____ Phone #: _____
Employer/Occupation: _____ Phone #: _____
Referring Doctor: _____ Referred By: _____
Primary Care Doctor: _____ Phone #: _____
Pharmacy: _____ Location: _____ Phone#: _____

INSURANCE INFORMATION- Please fill in line 1,2, and 3 coverage is through a spouse or a patient. Line 1 if self.

1.Primary Insurance: _____ ID#: _____ Group #: _____
2.Policy Holder: _____ Birthdate: _____
3.Social Security #: _____ Relation to Patient: _____
4.Language _____ Race: _____ Ethnicity _____

INSURANCE INFORMATION- Please fill in line 1,2, and 3 coverage is through a spouse or a patient. Line 1 if self.

1. Secondary Insurance: _____ ID#: _____ Group #: _____
2. Policy Holder: _____ Birthdate: _____
3. Social Security #: _____ Relation to Patient: _____
4. Language _____ Race: _____ Ethnicity: _____

**I HEREBY AUTHORIZE RELEASE OF ANY MEDICAL INFORMATION AND THE FILING OF INSURANCE CLAIMS
PERTAINING TO THE SERVICES RENDERED TO ME BY DELAWARE EYE SURGEONS, P.A.
CANCELTIONS LESS THEN 24 HOURS IS A FEE OF \$40.**

Patient Or Legal Guardian Signature: _____ Date: _____



Delaware Eye Surgeons
S. Gregory Smith, M.D. & Associates

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

Health Insurance Portability and Accountability Act
Patient Privacy Right and Disclosure

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

In compliance 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 any time, but be aware that we cannot guarantee care unless we can communicate with the other health professionals.

This consent becomes effective:

Patient or Legal Guardian Signature

Date

FINANCIAL POLICY FOR DELAWARE EYE SURGEONS, P.A.

INSURANCE

It is the patient's responsibility to supply ALL insurances at the time of visit. Failure to do so may result in claim denials, which then becomes the patient's liability.

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

ALL co-payments are due at time of service. Failure to pay co-pay at time of service may result in a late fee when billed. Any past due and payable balances are collected at the time of service.

SELF PAY ACCOUNTS

Self-pay accounts are patients with no insurance who pay out of pocket, 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 from the insurance company for a non-assigned claim, the patient will be refunded the amount paid. 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.

AUTOMOBILE ACCIDENT & WORKERS COMP CASES

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

CHILD CUSTODY CASES

The parent with custodial custody is usually the parent who the child lives with 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.

REFRACTIONS

Refractive services of routine eye exams are NOT covered by most medical 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.

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 or Legal Guardian Signature

Date: _____



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ABOUT YOUR INSURANCE

Our practice will verify your medical insurance before your appointment. Ex. Medicare and BC/BS.

- Medical insurance must be used if you have any health problems that ocular complications. Your doctor will determine if these conditions apply to you but some are determined by your case history.
- We will bill insurance plan for services if we are participating provider with that plan. We will try to obtain advanced authorization of your insurance benefits in the attempt to let you know what is covered. Any co-pays, deductibles or non-covered services will be your responsibility.

I have read and understand the above policies:

Patient or Legal Guardian 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 - Cpap 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

Pneumococcal Vaccination Yes No (Circle One)

Covid Vaccination Yes No (Circle One)

Please list ALL medicine **allergies:** _____

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

Smoking History: Current _____ Former _____ Never _____

Drinking History: Current _____ Former _____ Never _____

Height _____ Weight _____ Blood pressure _____

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)
<i>Example: Aspirin</i>	<i>Example: 80 mg</i>	<i>Example: By Mouth</i>	<i>Example: Once a day</i>

Name: _____ Date: _____

Patient Portal

Name: _____

Delaware Eye Surgeons is now offering our patients web-based access to communicate remotely. The patient portal allows the patient to request and appointment, update demographic information, leave messages among other things.

To enroll in the patient portal, please supply the receptionist with your e-mail. You will receive instructions through your e-mail on how to enroll.

E-mail _____ Or Decline

PRE-CATARACT SURGERY QUESTIONNAIRE

Name: _____

Survey Date: _____

Your eye care specialist has diagnosed cataracts in one or both of your eyes. Please answer the questions below to tell us how the cataract(s) are affecting your vision and your life. Do you have difficulty, even with glasses, with the following activities?

Pending surgery on: OD [] OS []

1. Do you have trouble reading small print on medicine bottle labels, a telephone book, or food labels?	☐ Yes	☐ No	☐ N/A
If yes, how much difficulty do you currently have?	☐ A Little	☐ A Moderate Amount	☐ A Great Deal
2. Do you have any difficulty reading newspaper or books?	☐ Yes	☐ No	☐ N/A
If yes, how much difficulty do you currently have?	☐ A Little	☐ A Moderate Amount	☐ A Great Deal
3. Are you having any problems with depth perception such as pulling in/out of the garage, going down steps, stairs, or curbs?	☐ Yes	☐ No	☐ N/A
If yes, how much difficulty do you currently have?	☐ A Little	☐ A Moderate Amount	☐ A Great Deal
4. Do you have any problems seeing oncoming cars, stop lights, traffic signals, street signs, or store signs?	☐ Yes	☐ No	☐ N/A
If yes, how much difficulty do you currently have?	☐ A Little	☐ A Moderate Amount	☐ A Great Deal
5. Are you bothered by glare in the evening, bright lights, sunlight, fluorescent lights, etc.? (circle which apply to you)	☐ Yes	☐ No	☐ N/A
If yes, how much difficulty do you currently have?	☐ A Little	☐ A Moderate Amount	☐ A Great Deal
6. Do you have trouble seeing while writing checks or filling out forms?	☐ Yes	☐ No	☐ N/A
If yes, how much difficulty do you currently have?	☐ A Little	☐ A Moderate Amount	☐ A Great Deal
7. Do you have any trouble seeing while doing activities like playing bingo, dominos, card games, or sports like golf or croquet?	☐ Yes	☐ No	☐ N/A
If yes, how much difficulty do you currently have?	☐ A Little	☐ A Moderate Amount	☐ A Great Deal
8. Do you have any difficulty doing fine handwork like sewing, knitting, crocheting, or carpentry?	☐ Yes	☐ No	☐ N/A
If yes, how much difficulty do you currently have?	☐ A Little	☐ A Moderate Amount	☐ A Great Deal
9. Do you have any problems watching television?	☐ Yes	☐ No	☐ N/A
If yes, how much difficulty do you currently have?	☐ A Little	☐ A Moderate Amount	☐ A Great Deal
10. Do you feel less independent due to your decreased vision?	☐ Yes	☐ No	

Cataract surgery can almost always be safely postponed until you feel you need better vision. If stronger glasses won't improve your vision anymore, and if the only way to help you see better is cataract surgery, do you feel your vision problem is bad enough to consider cataract surgery at this time?

Yes [] No []

Patient's Signature: _____