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.
CANCELATIONS 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.

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 sighing 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.

_____ Date: _____

Patient or Legal Guardian Signature

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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)
Example: Aspirin	*Example: 80 mg*	*Example: By Mouth*	*Example: Once a day*

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