Suburban Eye Specialists

Dr. Harriet Dann, M.D., F.A.C.S

PATIENT INFORMATION

Patient Name:_____ **Preferred Name**:_____ **Male** ☐ **Female** ☐
Last First Middle

Marital Status: Single ☐, Married ☐, Divorced ☐, Separated ☐, Widowed ☐ **Date of Birth**:_____

Race (check all that apply):☐American Indian or Alaska Native ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ Asian ☐ White

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino **Language**:_____

Home Address: _____
No. Street City State Zip

Home Phone:_____ **Work or Cell Phone**:_____
Email Address:_____ **Preferred Method of Contact**:_____

Referred By:_____ **Occupation**:_____

Preferred Pharmacy: _____
_____
Street City

Primary Care Doctor Name:_____ **Phone**:_____

HEALTH INSURANCE INFORMATION:

Medical Insurance Carrier Name:_____ **Insurance ID**:_____
Secondary Insurance:_____ **Insurance ID**:_____
Vision Carrier Plan:_____ **ID #**:_____
Policy Holder Name (other than yourself):_____
Last First Middle
Relationship: **Spouse** ☐ **Parent** ☐ **Step Parent** ☐

FINANCIALLY RESPONSIBLE PARTY (Other than insurance company)

Name:_____ **Home Phone**:_____
Address:_____ **Relationship to Patient**:_____

PATIENT/ GUARDIAN'S SIGNATURE:_____
DATE:_____

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MEDICAL HISTORY QUESTIONNAIRE

Name:_____ **Date:**_____

Date of Birth:_____ **Age:**_____

Allergies:_____

How did you hear about us:_____

List any medications you are currently taking including Insulin, eye drops, chemotherapy	**List surgeries you have had including eye surgeries.**

Circle any problems you have in the following areas.

	Yes	**No**	**Explain**
GENERAL/CONSTITUTIONAL			
Fever, Weight Loss			
EARS, NOSE, THROAT (Sinus, Ear Infection, Chronic Cough, Dry Mouth, Hearing Loss)			
CARDIOVASCULAR (Heart Disease, High Blood Pressure, Stroke, Cholesterol, Bypass)			
ENDOCRINE (Diabetes, Hypothyroid, etc.)			
RESPIRATORY (Asthma, Emphysema, Lung Cancer, etc)			
GASTROINTESTINAL (Stomach ulcers, Intestinal Disease,etc)			
GENITAL (Kidney, Bladder, Prostate)			
MUSCLES, BONES, JOINTS (Arthritis, Osteoporosis)			
SKIN (Acne, Warts, Skin Cancer, etc)			
NEUROLOGICAL (Multiple Sclerosis, Parkinson's Disease, Seizure Disorder, Myasthenia Gravia)			
PSYCHIATRIC (Anxiety, Depression, Insomnia)			
BLOOD / LYMPH (Anemia, Leukemia)			
ALLERGIC/ IMMUNOLGIC (Hay Fever, Lupus, Sjogrens, etc.)			
CANCER			
HEPATITIS			
HIV, AIDS			

PLEASE TURN OVER

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FAMILY HISTORY **M=mother** **F=father** **S=sibling** **GP=grandparent**

DISEASE	YES	NO	RELATIONSHIP TO PATIENT
Macular Degeneration			
Glaucoma			
Cataracts			
Lazy Eye			
Retinal Detachment			
Diabetes			
Heart Disease			
High Blood Pressure			
Cancer			
Stroke			
Thyroid Disease			
Other			

SOCIAL HISTORY (circle one)

1. Marital Status: married, divorced, single, widowed
2. Do you drink alcohol? Yes, No, Occasionally
3. Do you smoke? Yes, No, Used to smoke for _____ years
4. Do you Drive? Yes, No
5. Do you have visual difficulty when driving? Yes, No
6. Do you wear glasses? Yes, No
7. Do you wear contacts? Yes, No

Physician's Signature:_____ Date:_____

Tech/ RN:_____ Date:_____

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Eye Physician and Surgeon

AUTHORIZATION TO RECEIVE/RELEASE HEALTH INFORMATION

Due to the **HIPAA Compliance Privacy Laws of the Federal Government,** it is mandatory that we ask you to review and answer the following questions listed below.

Name: _____

May we leave messages/detailed medical information on voicemail at either of these phone numbers?

□ Yes □ No Home Phone: _____ □ Yes □ No Cell Phone: _____

May we contact you at your place of employment? □ Yes □ No

If so, may we leave a message? □ Yes □ No

If yes: Work Phone: _____ Extension: _____

Do you have any particular person or family members that you authorize to receive and discuss information regarding your personal health information (general information, surgical and billing)?

□ Yes □ No If yes, please provide:

Name: _____ Relationship: _____

Phone Number: _____ Alternate Number: _____

Is this person your Power of Attorney for medical purposes? □ Yes □ No

Name: _____ Relationship: _____

Phone Number: _____ Alternate Number: _____

I hereby authorize Suburban Eye Specialists, PC to obtain or release any and all pertinent information regarding my medical care, as needed, to assist in my ongoing treatment to or from other health care providers, laboratories, radiology facilities or other institutions. **This authorization remains in effect until revoked.**

I have reviewed the aforementioned information and provide my consent regarding any and all the issues as stated above.

I have reviewed Suburban Eye Specialists Notice of Privacy Policy. A copy of this policy will be provided to me upon request.

Patient Signature: _____ Date:_____

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Eye Physician and Surgeon

Suburban Eye Specialists is in the process of implementing ePrescribing in each of our offices.

ePrescribing is a federally mandated initiative that requires all physicians prescribe in this manner by 2011.

ePrescribing software sends prescriptions over the internet to your pharmacy in a safe, secure way, through the same technology used by credit card companies. This helps protect the privacy of your personal information.

ePrescribing software also lets your doctor see important information - like drug interactions and your prescription history.

The benefit to you:

- **Less confusion over handwritten prescriptions or unclear phone calls**
- **Reduced possibility of medical errors**
- **Less chance of adverse drug reactions**
- **Fewer trips to drop off at the pharmacy**
- **A safer, faster, easier way to get your prescription filled**

Patient Consent

I agree that Suburban Eye Specialists may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

_____ _____

Patient Signature **Date**

Norwood- MAIN OFFICE
781-769-2508
Guild Medical Center
825 Washington Street, Suite 160
Norwood, MA 02062

Faulkner Hospital Office
617-522-4032
1155 Centre Street, Suite 35
Jamaica Plain, MA 02130

Needham Office
781-444-1832
100 West Street, Suite 2
Needham, MA 02494

Suburban Eye Specialists

Financial Policy

TO ALL PATIENTS: The following information is provided to assist you in understanding how your bill for services will be processed. Please read this as it pertains to your situation and then sign it so that we may have it on your record. We will make every effort to process your bill in the most efficient manner available. Therefore, please understand that having accurate information at the start of your care will minimize errors in the billing process.

HEALTH INSURANCE COVERAGE: We require a photocopy of your insurance card. Your card provides necessary information for billing purposes. We need the name, address, phone number, member number and group number for your plan. Insurance companies will not process claims without this information. If this information is not provided at the time of the visit, the patient may be responsible for payment.

MANAGED CARE PLANS: These are insurance plans that require referral from your primary care physician to your specialist. Obtaining a referral for service is **your** responsibility. This referral should be obtained prior to your visit. Referrals are limited in number and follow up visits may require a new referral. Generally, after the fact referrals are not issued by your PCP or insurance plan.

VISION PLANS: It is your responsibility to know if you are covered for routine vision care under your health insurance plan or by a separate vision plan. Please note that if additional testing is performed or if you have a medical reason **(corneal disorders, diabetes, cataracts, glaucoma suspect, double vision, etc)** then we will be billing your medical insurance and any applicable deductibles or copayments will apply. If you have any questions, please speak with a staff member before beginning your exam.

CHANGE OF HEALTH INSURANCE CARRIERS: We must be notified if your insurance policy changes to a different carrier. We will need a copy of the new insurance card and the effective date of change. If you are changing to a managed care plan, you must obtain a new referral from your PCP for the new plan, even if you are in the middle of treatment.

REFRACTIONS: Medicare and most private carriers do not cover the cost of the refraction. The fee for this service will be $25.00 and will be collected at the time of service. Refraction is the process of determining the eye's refractive error, or need for corrective glasses and/or contact lenses. For example a patient experiencing blurred vision or a decrease in visual acuity on the eye chart would need a refraction to see if this is due to a medical problem or glasses. A refraction is also necessary to prove to insurance companies the need for cataract surgery. If you decline the refraction we may not be able to determine the cause for your decrease in vision. This fee is due and payable whether or not you receive a written glasses prescription. Sometimes the change is not significant enough to warrant the cost of purchasing new glasses and a new prescription will not necessarily be given unless requested.

NO SHOWS: All missed appointments and cancellations with less than 24 hours notice will be charged $25.00. You will need to pay the $25.00 before a new appointment can be made. **Insurance DOES NOT pay for this.**

If you are not sure that a service is covered, please refer to your benefits book or call your insurance plan and ask. You are responsible for all charges not covered by your insurance. Copayments are due at the time of service or an administrative fee will be added. If you have any questions about your coverage please call your carrier. If you have any questions regarding our policies, please call our office at 781-769-2508.

I have read the above policy and understand the terms as it pertains to my particular situation. I agree to discuss any billing issues with the billing manager and understand that I am ultimately responsible for providing complete information and payment of balance dues.

_____ _____

DATE **PATIENT / LEGAL GUARDIAN SIGNATURE**