MaculaCare

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GENERAL INFORMATION

Name: _____
(first name) *(M.I.)* *(last name)*

Address: _____
(street address) *(apt)* *(city)* *(state)* *(zip code)*

Phone: (____)_____ Cell: (____)_____

E-mail Address: _____

Sex: ____ Age: ____ Birthdate: _____ Social Security: _____

Occupation: _____ Employer: _____

In case of emergency, please contact:

Name: _____ Relationship: _____

Home Phone: (____)_____ Work Phone: (____)_____

Who referred you to MaculaCare? _____

Name of Internist: _____

Name of General Ophthalmologist: _____

INSURANCE INFORMATION

Who is responsible for account? _____ Relationship to patient: _____

Primary Insurance Company: _____ Policy Number: _____

Secondary Insurance Company: _____ Policy Number: _____

Assignment and release:

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign to MaculaCare all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize MaculaCare to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

X _____ Relationship: _____ Date:_____

I acknowledge that I have received a copy of MaculaCare's **NOTICE OF PRIVACY PRACTICES:**

X _____ Date: _____

Medicare Authorization (if applicable)**:**

I request that payment of authorized Medicare benefits be made either to me or on my behalf to MaculaCare for any services furnished to me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. "Other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorized releasing of the information to the insurer's Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier**.**

X _____ Date**:** _____

MEDICAL INFORMATION

What is the main problem concerning your eye(s)? _____

_____

How long have you been having these symptoms? _____

How severe are your symptoms? _____

Are these symptoms increasing or decreasing in intensity over time? _____

Does anything make your symptoms better or worse? _____

Have you had previous eye surgery? _____

Past Hospitalizations, Surgeries or Major Medical Events:

_____ _____

_____ _____

Current Medical Conditions:

_____ _____

_____ _____

_____ _____

Current Medications & Doses:

_____ _____

_____ _____

_____ _____

_____ _____

Please List Food or Drug Allergies: **Reaction:**

_____ _____

_____ _____

Tobacco Use: _____ **Alcohol Use:** _____

(#Packs/Day or specify if a past smoker) (#Drinks/Day/Week)