■ 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: (____)______________________ Cell : (____)____________________

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: ______________________
(#Packs/Day or specify if a past smoker)

Alcohol Use: ______________________
(#Drinks/Day/Week)