GREATER MARYLAND EYE PHYSICIANS & SURGEONS

Medical History Questionnaire

Name: _____ Date: _____

Date of last eye examination: _____/_____/_____

List all current medications (prescription and over the counter):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

Do you have any allergies to any medications? ☐ Yes ☐ No If yes, Please list:

Medication		Symptoms
1. _____	-	_____
2. _____	-	_____
3. _____	-	_____
4. _____	-	_____

Illness Past and Present	Yes	No	Duration	Family History	Yes	No	Relationship
Glaucoma				Glaucoma			
Arthritis				Arthritis			
Cancer				Cancer			
Diabetes				Diabetes			
Heart Disease				Heart Disease			
High Blood Pressure				High Blood Pressure			
Kidney Disease				Kidney Disease			
Stroke				Stroke			
Thyroid Disease				Thyroid Disease			
Asthma/Emphysema				Asthma/Emphysema			
AIDS/HIV				AIDS/HIV			
Hay Fever or Sinus				Hay Fever or Sinus			
Others:				Others:			

List any ***eye surgeries*** you have had (cataract, corneal transplant, etc.):

_____

_____

List any ***surgeries*** you had had (appendectomy, tonsillectomy, etc.):

_____

_____

Occupation: _____

Marital Status: (circle one) married / divorced / single / widowed

Do you drive? ☐ Yes ☐ No

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, what year? _____

Do you smoke? ☐ Yes ☐ No If yes, how many packs/day? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks/week? _____

Do you currently have any of the following areas? If yes, please provide information.

REVIEW OF SYSTEMS (Examples)	YES	NO	EXPLANATION OF PROBLEM
EYES (glaucoma, cataracts, blurred vision)			
GENERAL (fever, weight loss, fatigue)			
EARS, NOSE, THROAT (earaches, nose bleeds, sinus disease, sore throat)			
CARDIOVASCULAR (chest pain, palpitations)			
RESPIRATORY (cough, shortness of breath, wheezing)			
GASTROINTESTINAL (nausea, vomiting, heartburn, loss of appetite)			
GENITOURINARY (frequent urination, kidney stones, blood in urine)			
MUSCULOSKELETAL (joint pain, muscle weakness)			
SKIN (rash, acne, skin cancer, warts)			
NEUROLOGICAL (headaches, paralysis, seizures)			
PSYCHIATRIC (depression, anxiety, memory loss)			
ENDOCRINE (diabetes, hypothyroid)			
HEMATOLOGIC (anemia, bleeding, bruising tendencies)			
ALLERGIC/IMMUNOLOGIC (hay fever, lupus, HIV)			

Office Use Only:

History reviewed. ☐ No changes ☐ Changes as above

Date: ____/____/____ Doctor's Signature: _____

Greater Maryland Eye Physicians & Surgeons

REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Last name:	First Name:	Middle Name:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital Status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ☐Yes ☐ No	If not, what is your legal name?	**Email Address:**	Birth date: / /	Age:	Sex:

Mailing Address:

City: State: Zip Code:

Home Phone #:	**Cell Phone #:**	**Work Phone #:**

How did you hear about our office?	Is This A Work Related Injury?

Employer Name: Occupation:

Primary Care Physician:

INSURANCE INFORMATION

Primary Insurance Carrier:

Subscriber Name:

Date of Birth: Social Security:

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other	
Name of Secondary Insurance Carrier:	Subscriber's name:			Date of Birth:	Social Security:
Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other	

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home Phone #:	Work Phone #:

The above information is true to the best of my knowledge. I authorize GMEPS to render treatment to me or my dependent. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize GMEPS or my insurance company to release any information required to process my claims. Responsible party of patient will be responsible for all collection or court costs associated with delinquent accounts. Responsible party is also responsible for service charges resulted from delinquent accounts. There will be a $35 fee for all returned checks.

X_____ X_____

Patient/Guardian Signature ***Date***

GREATER MARYLAND EYE PHYSICIANS & SURGEONS

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: _____

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

I hereby authorize GMEPS 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 **REFRACTION Notice** and **Notice of HIPAA Privacy Policy**. A copy of this policy will be provided to me upon request.

Patient Signature: _____ **Date**: _____

WITNESSED BY: _____

GREATER MARYLAND EYE
PHYSICIANS & SURGEONS

Explanation of Refraction Fee

The refraction fee is the part of your eye exam by which we determine if your vision can be improved with a new glasses prescription. It is also how we determine the best possible visual acuity and function of your eye, which is essential medical information for us to have as we assess your eyes and look for problems. It is **NOT** a covered service by Medicare and many other insurance plans. These plans consider a refraction as a "vision" service and not a "medical" service. The physicians in our office are medical doctors and surgeons.

Contact lens exams are also a non-covered service and vary in cost depending on the type of fitting.

Our refraction fee is **$50.00** and unless your plan automatically covers the refraction charge, this fee is collected at the time of service in addition to any co-payment that your insurance may require. Should your plan pay us for the refraction, we will reimburse you accordingly.

Refraction fee does not apply if your prescription is changed during your post-operative period.

By signing I acknowledge that I have reviewed and understand the Explanation of Refraction Fee form. If I want a glasses prescription update/renewal, I agree to pay any fees related to this non-covered service.

X_____ X_____

Patient/Guardian Signature ***Date***

X_____

Patient/Guardian (Print Name)

GREATER MARYLAND EYE PHYSICIANS AND SURGEONS

9131 Piscataway Road Suite 450 Clinton, MD 20735

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Understanding your health record

A record is made each time you visit a hospital, physician, or other health care provider. Your symptoms, examination, test results, diagnoses, treatment and a plan for future care are recorded. This information is most often referred to as your "health or medical record," and serves as a basis for planning your care and treatment. It also serves as a means of communication among any and all other health professionals who may contribute to your care. Understanding what information is retained in your record and how that information may be used will help you to ensure its accuracy and enable you to relate to who, what, when, where, and why others may be allowed access to your health information. This effort is being made to assist you in making informed decisions before authorizing the disclosure of your medical information to others.

Understanding your health information rights

Your health record is the physical property of the health care practitioner or facility that compiled it but the content is about you and therefore belongs to you. You have the right to request restrictions on certain uses and disclosures of your information, and to request amendments be made to your health record. Your rights include being able to review or obtain a paper copy of your health information, and to be given an account of all disclosures. You may also request communications of your health information be made by alternative means or to alternative locations. Other than activity that has already occurred, you may revoke any further authorizations to use or disclose your health information.

Our responsibilities

This office is required to maintain the privacy of your health information and to provide you with notice of our legal commitment and privacy practices with respect to the information we collect and maintain about you. This office is required to abide by the terms of this notice and to notify you if we are unable to grant your requested restrictions or reasonable desires to communicate your health information by alternative means or to alternative locations. This office reserves the right to change its practices and effect new provisions that enhance the privacy standards of all patient medical information. In the event that changes are made, this office will notify you at the current address provided on your medical file. Other than for reasons described in this notice, this office agrees not to use or disclose your health information without your authorization.

OVER ⟶

GREATER MARYLAND EYE PHYSICIANS AND SURGEONS

9131 Piscataway Road Suite 450 Clinton, MD 20735

To receive additional information or report a problem

For further explanation of this notice you may contact the Practice Administrator at 301-868-6700. If you believe your privacy rights have been violated, you have the right to file a complaint with your medical office or with the Secretary of Health and Human Services with no fear of retaliation by this office.

Your health information will be used for treatment, payment, and health care operations

Treatment – Information obtained by your health practitioner in this office will be recorded in your medical record and used to determine the course of treatment that should work best for you. This consists of your physician recording his/her own expectations and those of others involved in providing you care. The sharing of your health information may progress to others involved in providing you care. The sharing of your health information may progress to others involved in your care such as specialty physicians or lab technicians.

Payment – Your health care information will be used in order to receive payment for services rendered by this office. A bill may be sent to either you or a third-party payer with accompanying documentation that identifies you, your diagnosis, procedures performed and supplies used.

Health Care Operations – The medical staff in this office will use your health information to assess the care you received and the outcome of your case compared to others like it. Your information may be reviewed for risk management or quality improvement purposes in our efforts to continually improve the quality and effectiveness of the care and services we provide.

Problems or concerns: To file a complaint with the Secretary of Health and Human Services you may contact them at the address below:

Region III, Office of Civil Rights
US Dept of Health and Human Services
150 South Independence Mall West
Suite 372
Public Ledger Building
Philadelphia, PA 19106-9111
Phone: 1-800-368-1019
Fax: 215-861-4431

You will not be penalized for filing a complaint

X_____ X_____

Patient/Guardian Signature *Date*

X_____

Patient/Guardian (Print Name)