

**Pediatric Ophthalmology Associates, Inc.**

**ADULT PATIENT INFORMATION**

<b>PATIENT NAME</b>  (Last) (First) (Middle) (Preferred Name)	<b>SEX</b> <input type="checkbox"/> Male	<b>RACE</b>	<b>ETHNICITY</b>	<b>AGE</b>	<b>DATE OF BIRTH</b>
	<input type="checkbox"/> Female				

**ADDRESS**  
  
(Street) (City) (State) (Zip)

<b>HOME PHONE</b> <b>CELL PHONE</b> <b>MAY WE LEAVE A MESSAGE?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>EMAIL ADDRESS</b>
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<b>SOCIAL SECURITY NUMBER</b>	<b>PLACE OF EMPLOYMENT</b>
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<b>MARRITAL STATUS:</b> <input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOWED <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED	<b>EMPLOYMENT STATUS:</b> <input type="checkbox"/> FULL TIME <input type="checkbox"/> PARTTIME <input type="checkbox"/> RETIRED <input type="checkbox"/> UNEMPLOYED <input type="checkbox"/> DISABLED
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<b>SPOUSE</b>  (Last) (First) (Middle)	<b>SSN</b>	<b>AGE</b>	<b>DATE OF BIRTH</b>
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**BRIEFLY DESCRIBE THE PATIENT'S CHIEF COMPLAINT**

**IS ANOTHER FAMILY MEMBER SEEN HERE?** (NAME OF PATIENT AND NAME OF PHYSICIAN)

**PHYSICIAN INFORMATION**

**FAMILY PHYSICIAN** (NAME, ADDRESS AND PHONE NUMBER)

**REFERRING PHYSICIAN** (NAME, SPECIALTY, ADDRESS AND PHONE)

**PRIMARY INSURANCE**

**INSURANCE COMPANY NAME AND ADDRESS**

<b>MEMBER NAME</b>	<b>SUBSCRIBER NAME</b>	<b>MEMBER SS#</b>
<b>MEMBER ID</b>	<b>EFFECTIVE DATE</b>	

**SECONDARY INSURANCE**

**INSURANCE COMPANY NAME AND ADDRESS**

<b>MEMBER NAME</b>	<b>SUBSCRIBER NAME</b>	<b>MEMBER SS#</b>
<b>MEMBER ID</b>	<b>EFFECTIVE DATE</b>	

Signature \_\_\_\_\_

Date \_\_\_\_\_

Patient name: \_\_\_\_\_ MR# \_\_\_\_\_ Date \_\_\_\_\_

REVIEW OF SYSTEMS: please check any of the following symptoms you are currently experiencing

TOBACCO USE:  Yes  No

ALL NORMAL  Patient has none of the following issues:

**GENERAL/CONSTITUTIONAL**

- Fever
- Weight Loss
- Weight Gain
- Fatigue
- Weakness
- Other: \_\_\_\_\_

**INTEGUMENTARY (SKIN)**

- Rashes
- Dryness
- Sores
- Suspicious Growth
- Eczema
- Other: \_\_\_\_\_

**EARS/NOSE/MOUTH/THROAT**

- Decreased Hearing
- Wears Hearing Aids
- Ringing in Ears (tinnitus)
- Nosebleeds
- Sinus Pain
- Sore Throat
- Other: \_\_\_\_\_

**RESPIRATORY**

- Cough
- Shortness of Breath
- Wheezing
- Other: \_\_\_\_\_

**CARDIOVASCULAR**

- Chest Pain and Discomfort
- Palpitations
- Murmur
- Other: \_\_\_\_\_

**GASTROINTESTINAL**

- Nausea
- Vomiting
- Reflux
- Change in Appetite
- Constipation
- Diarrhea
- Feeding Tube
- Other: \_\_\_\_\_

**GENITOURINARY**

- Blood in Urine
- Incontinence
- Sores
- Other: \_\_\_\_\_

**MUSCULOSKELETAL**

- Muscle or Joint Pain
- Stiffness
- Swelling of Joints
- Hypotonia
- Weakness
- Paralysis
- Other: \_\_\_\_\_

**NEUROLOGIC**

- Dizziness
- Fainting
- Seizures
- Weakness
- Numbness
- Tingling
- Tremor
- Decreased Memory
- Shunt Placement
- Tic
- Other: \_\_\_\_\_

**ENDOCRINE**

- Heat or Cold Intolerance
- Sweating
- Poor Blood Sugar Control
- Growth Problem
- Other: \_\_\_\_\_

**HEMATOLOGIC/LYMPHATIC**

- Easy Bruising
- Easy Bleeding
- Other: \_\_\_\_\_

**PSYCHIATRIC**

- Anxiety
- Depression
- Stress
- Hyperactivity
- Distractibility
- Other: \_\_\_\_\_

**ALLERGIES/IMMUNOLOGIC**

- Environmental Allergies
- Reduced Immunity
- Other: \_\_\_\_\_

**PAST MEDICAL HISTORY (EVEN IF NO SYMPTOMS CURRENTLY)**

**ANY ADDITIONAL HEALTH INFORMATION FOR OUR DOCTORS**

**Preferred Pharmacy**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

REVIEWED MEDICAL HX DATED \_\_\_\_\_

DOCTOR'S INITIALS: \_\_\_\_\_

# GENERAL CONSENT

PEDIATRIC OPHTHALMOLOGY ASSOCIATES, INC.

555 S. 18<sup>TH</sup> ST. 4-C

Columbus, Ohio 43205

614 224-6222 614-241-5232 (fax)

## Consent for Medical Treatment:

I and/or my parent(s) or guardian(s)\* consent to let the doctors, technicians and employees of Pediatric Ophthalmology Associates\*\*, Inc. do all things that may be necessary to diagnosis, treat and care for the needs of

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PATIENT'S NAME

(\* From now on in this document, "I" will refer to: "I and my parent(s) or guardian(s)."

(\*\* From now on in this document the "Practice" will refer to Pediatric Ophthalmology Associates.)

## Patient Rights and Responsibilities

I understand that I have the right to take part in decisions about my health care and plan for treatment.

## Consent to Release Medical Information

I consent to let the Practice share/release information such as clinical, physical, mental, drug, alcohol, HIV or AIDS (including information that state and federal law and accreditation agencies require) to/with my doctors, my referring doctors or referring/referral healthcare provider; and to any insurance company or organization that helps pay my bill. The Practice may also give information to any welfare organization, to which I apply or may apply for aid.

## Assignment of Insurance Benefits:

I consent to let the Practice bill my insurance companies, or other third party payor and allow those insurance companies or payors to pay the Practice directly for healthcare services provided. I understand that the insurance companies could send payment to me and I will be responsible for turning that money over to the Practice.

The Practice may ask Medicare or Medicaid to pay my bills if I am covered. Further, I confirm that the information given by me in applying for payment is correct.

## Financial Responsibility:

I (or guarantor if appropriate) will pay all bills for my care including bills that insurance benefits do not pay.

## Acknowledgement of Receipt of Privacy Practices:

I hereby acknowledge that I  received  declined a copy of the Notice of Privacy Practices of Pediatric Ophthalmology Associates which sets forth the ways that my protected health information may be used or disclosed by Pediatric Ophthalmology Associates, and outlines my rights with respect for such information.

I agree to allow this consent to be effective until I notify the Practice in writing that I want to change or revoke it.

AND

If there is a change in custody, I will notify the Practice at my next visit.

Signed \_\_\_\_\_  
PARENT/GUARDIAN IF PATIENT IS LESS THAN 18      PATIENT IF 18 YEARS OR OLDER      DATE

PRINT NAME OF THE PERSON SIGNING      RELATIONSHIP TO PATIENT

Signed \_\_\_\_\_  
WITNESS      DATE

# PEDIATRIC OPHTHALMOLOGY ASSOCIATES, INC.

## INSURANCE NOTICE

Our office is committed to making your visit a pleasant one. As a courtesy to you, we are happy to assist you with filing your insurance claims. To help you to understand our process, we have put together this summary of our billing policies.

### Insurance Coverage

At each visit we will verify your address and phone number, update the medical history and verify your insurance coverage. Please bring the following to each visit:

- Copies of all Medical Insurance ID Cards
- Your Medical Insurance Copay
- Information on any Vision Plan Coverage

### Referrals

Because the doctors are specialists, your insurance may require a referral. If a referral is not on file, your insurance may refuse to cover the service. Charges for services denied for lack of a referral will be billed to you.

### Covered Services

Unfortunately, there are limits to insurance coverage. In some cases there are conditions or procedures that may not be covered by your insurance. These procedures may include:

- **ROUTINE OR PREVENTATIVE EYE EXAMS**
- **REFRACTIONS**
- **CONTACT LENS SERVICES**

If your insurance does not cover these services, you agree to be personally and fully responsible for payment.

I acknowledge that I have read and understand the billing policies of Pediatric Ophthalmology Associates.

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Signature

Date