PATIENT INFORMATION FORM

THIS SECTION REFERS TO PATIENT ONLY

Name:	Sex:	Birth Date:
Social Security #:	Marital Status: ☐ S ☐ M ☐ D ☐ W	
Address:	City: State:	Zip:
Home Phone:	Mobile Phone:	Work Phone:
Employer Name:	Employer Address:	
Spouse's Name:	Spouse's Employer:	
Emergency Contact:	Relationship to Patient:	Phone:

DEMOGRAPHIC INFORMATION

The information in this section is required for compliance with federal electronic health records guidelines. You may decline to answer.

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Decline to Answer

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to Answer

Preferred Language: _____

IF PATIENT IS A MINOR

Father's Name:	Birth Date:	Social Security #:
Employer Name:	Employer Address:	Employer Phone:

Mother's Name:	Birth Date:	Social Security #:
Employer Name:	Employer Address:	Employer Phone:

Name of School:	Guardian Name(s):

RELEASE OF INFORMATION

I authorize my physician, health care provider, and their representatives to release any information relating to an illness, injury, diagnosis, care or treatment to my insurance company, health plan, Medicare, Medicaid, or third party payer or their agents, contractors, subcontractors or affiliates provided they agree such information is kept confidential. Such information shall include, but is not limited to any medical records and medical information, including: psychiatric, psychological, nervous/mental, substance abuse (e.g. alcohol and drug abuse) and HIV and HIV-related information. I understand that the reason for furnishing such information may include the following: for use in medical, financial or provider auditing, or such other auditing as may be legally required; for utilization and/or quality of care review and assessment; and for determining available health benefits and coverage.

I assign directly to Dr. Famiglietti all medical 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. In Medicare-assigned cases, Dr. Famiglietti agrees to accept the charge determination of the 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.

_____ _____

Signature of patient (or parent) Date

PATIENT HISTORY RECORD

▲ DATE (MM/DD/YY) ▲ REFERRED BY ▲ BIRTH DATE

▲ PATIENT'S NAME ▲ SEX ▲ AGE

▲ ADDRESS ▲ PHONE (H)

▲ EMPLOYER ▲ OCCUPATION ▲ PHONE (W)

▲ SOC. SEC. NO. ▲ PRIMARY CARE PHYSICIAN

Please answer the following questions about your medical status and history:

1. Have you ever been treated for any medical conditions (e.g. diabetes, high blood pressure, arthritis, etc.)?
   Yes ☐ No ☐ If Yes, please explain: _____
2. Have you ever had any eye disease (eg. glaucoma, cataract, wandering or "lazy" eye, retinal detachment)?
   Yes ☐ No ☐ If Yes, please explain: _____
3. Have you ever had any surgery?
   Yes ☐ No ☐ If Yes, please provide date and reason: _____
   _____
4. Have you ever been hospitalized?
   Yes ☐ No ☐ If Yes, please provide date and reason: _____
   _____
5. Do you take any medications?
   Yes ☐ No ☐ If Yes, please list: _____
   Do you take any eye medications?
   Yes ☐ No ☐ If Yes, please list: _____
6. Do you have any drug or food allergies?
   Yes ☐ No ☐ If Yes, please list: _____
   _____

Review of Systems

Do you currently have any of the following problems:	Yes	No	If Yes, please explain:
Chronic fever, unexpected weight loss/gain, fatigue	☐	☐	_____
Ear/nose/throat problems (e.g. hearing loss, sinus problems, sore throat)	☐	☐	_____
Heart problems (e.g. chest pain, irregular heart beat)	☐	☐	_____
Respiratory problems (e.g. shortness of breath, wheezing, coughing)	☐	☐	_____
Gastrointestinal problems (e.g. heartburn, abdominal pain, diarrhea, vomiting)	☐	☐	_____
Urinary problems (e.g. pain or discomfort, blood in urine)	☐	☐	_____
Skin problems (e.g. rashes, excessive dryness)	☐	☐	_____
Musculoskeletal problems (e.g. muscle aches, joint pain, swollen joints)	☐	☐	_____
Neurologic problems (e.g. numbness, weakness, headaches, paralysis)	☐	☐	_____
Psychiatric problems (e.g. depression, anxiety)	☐	☐	_____

Family and Social History

Do any medical or eye diseases run in your family (e.g., diabetes, high blood pressure, cancer, glaucoma, macular degeneration)
Yes ☐ No ☐ If Yes, please explain: _____
_____

Do you smoke? If yes, how much? _____ drink alcohol? If yes, how much? _____

If employed, how many hours per week do you work? _____

▲ COMMENTS

▲ M.D. SIGNATURE ▲ DATE

FAMIGLIETTI EYE ASSOCIATES
PATIENT AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Please print patient's name: _____

Unless otherwise indicated, the sharing of the above-named patient's medical information will be restricted to his or her immediate family.

The patient or his or her legal representative may request that the list of people involved with his or her medical care be expanded or restricted. The patient has the right to amend this list at any time.

Please check all boxes to whom it is appropriate to share medical information. Add any qualifier or restrictions as necessary.

- ☐ Spouse Name: _____
- ☐ Child(ren) Name(s): _____
- ☐ Parent(s) Name(s): _____
- ☐ Other family member Name: _____
- ☐ Other – please specify relationship Name: _____

_____ _____

Signature of patient or legal representative Date

I give permission for medical information to be left on my answering machine or voicemail. Please check all that apply:

- ☐ Appointment information
- ☐ Test results
- ☐ Prescription or prescription change information

Home phone: _____ Mobile phone: _____

_____ _____

Signature of patient or legal representative Date

FAMIGLIETTI EYE ASSOCIATES
NOTICE TO OUR PATIENTS

REFRACTION

Your eye exam may include a refraction. The refraction is the part of the exam by which we determine whether your vision can be improved by glasses or contact lens correction. We perform refractions for all new patients and periodically as needed for existing patients. Medicare does not cover this service and coverage varies from company to company and plan to plan. Please contact your insurer to determine if your plan covers the refraction (CPT code 92015). **If your insurance company does not cover the refraction you may receive a bill.**

DEDUCTIBLE AND OTHER OUT-OF-POCKET COSTS

Our patients have many, many insurance policies, the terms of which are constantly changing. **Our practice cannot give you advice as to what your plan covers.** Your plan may include a deductible, co-insurance, or copays, amounts that are payable by you. We will submit your claim to your insurance company; they will tell us what amount they will cover and what amount you will be responsible for under the terms of your plan. **We are required to bill you for the amount your insurance company determines is your responsibility.**

ROUTINE CARE

Some insurance plans offer one "routine," "preventive," or "wellcare" visit every year or two years. In our experience this often means the insurance company fully covers only the office visit, which is the time you spend with the doctor. Your insurance company may or may not consider a test, even a refraction, to be part of a routine exam. For example, an eye exam for a new patient typically consists of the office visit, the refraction, and fundus photos and/or dilation. Your insurance company may or may not intend to cover all three exam components in full as part of a routine exam. Services not considered "routine" by your insurance company would be subject to the other terms of your policy.

If you are here to fulfill this particular plan benefit, please let us know prior to seeing the doctor. Please note that if your plan does not offer this benefit, your claim will be denied.

REFERRALS

If your insurance policy requires you to obtain a referral before seeing a specialist, please do so in advance of your appointment. Our practice is not responsible for requesting referrals. If your plan requires a referral and you do not have one, we will have to reschedule your appointment.

_____ _____

Signature of patient or legal representative Date

_____

Please print patient's name