Metayer Family Eye Care

Patient Intake Form

Date of Birth: _____ Today's Date: _____

Name: Last _____ First _____ MI _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Phone: ☐Home _____ ☐Work_____ ☐Cell _____

☐ Email address: _____

(please check off the <u>ONE</u> best way to contact you during the day)

Employer: _____ Occupation: _____

Social Security Number: _____ Birth State: _____

Marital Status: ☐divorced ☐domestic partner ☐married ☐separated ☐single ☐widowed

Who is responsible for payment? _____

(We accept: cash, checks, Visa, Mastercard and Discover)

If minor child, name of parent: _____

Ethnicity

☐ Hispanic or Latino ☐ Native American / Alaska Native ☐ African American ☐ Asian
☐ Pacific Islander ☐ White ☐ Decline / Unknown ☐ Other

Please continue to page 2 →

History of Present Illness

What is the primary reason for today's visit? _____

_____

Was your last eye exam here? ☐YES ☐NO

If **NO**, Date of last eye exam: _____with Dr._____

Do you wear eyeglasses? ☐currently ☐previously ☐never

Do you wear contact lenses? ☐currently ☐previously ☐never

General health

Date of last ***medical*** exam: _____ with Dr._____

Do you take any medications? ☐YES ☐NO If yes, please list *(or give to receptionist to copy)*:

_____

_____

Do you have any allergies? ☐YES ☐NO *(please list, including allergies to medications):*_____

_____

_____

Have you had any recent *(within ONE year)* surgeries? ☐ YES ☐NO

*If yes, list date and type of surgery:*_____

Please Continue to page 3 →

Ocular/Medical History

Have you ever had a serious eye injury? ☐right eye ☐left eye ☐never
specify type: _____ *date of injury:* _____

Have you ever had eye surgery? ☐right eye ☐left eye ☐never
specify type: _____ *date of surgery:* _____

Do you have /Had a history of any of the following?

Glaucoma:	☐ self	Strabismus:	☐ self
Cataracts:	☐ self	Amblyopia:	☐ self
Macular degeneration:	☐ self	Other condition / disease:	☐ self
		specify: _____	
Arthritis:	☐ self	High cholesterol:	☐ self
Asthma:	☐ self	High blood pressure:	☐ self
Diabetes:	☐ self	Thyroid condition:	☐ self
Cancer:	☐ self	Other:	☐ self
Heart disease:	☐ self	*specify:* _____	

Family History

Does anyone in your family (parents/Brothers/sisters) have any of the following? Who?

☐ Glaucoma _____ ☐ Diabetes _____
☐ Blindness _____ ☐ Heart Disease _____
☐ Macular Degeneration _____ ☐ Other _____

Social History

How often do you drink alcohol?	☐never	☐socially	☐moderate	☐daily
How often do you smoke?	☐never	☐previous	☐some days	☐every day

What are your hobbies?_____

Please continue to HIPAA Consent Form and/or Insurance Release Form →

HIPAA Consent Form

Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the Law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to restrict how protected health information about you is disclosed for treatment, payment or healthcare operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and healthcare operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

SUMMARY OF PRIVACY PRACTICES

This summary of our privacy practices contains a condensed version of our Notice of Privacy Practices. Our full-length notice is available in our office, and will be supplied to you upon request. Date of last revision April 14, 2003. Effective date: Immediately

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS CAREFULLY.

We understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create medical records about your health, our care for you, and the services and/or items we provide to you as our patient. By law, we are required to make sure that your protected health information is private.

How will we use or disclose your information? Here are a few examples:

- For medical treatment
- To obtain payment for services
- In emergency situations
- For appointment and patient recall reminder
- To efficiently co-manage patient care with specialists and primary care physicians
- For research
- To avert a serious threat to health or safety
- For organ and tissue donation
- For workers' compensation programs
- In response to certain requests arising out of other disputes

If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of Department of Health and Human Services. To file a complaint with the practice, contact our Office Manager, Melissa O'Brien. All complaints must be submitted in writing. You will not be penalized for filing a complaint. You have certain rights regarding the information we maintain about you. These rights include:

- The right to inspect your records
- The right to amend
- The right to an accounting of disclosures
- The right to request restrictions
- The right to a paper copy of this notice
- The right to request confidential communications

I acknowledge that I have been given access to a copy of the Providers Notice of Privacy Practices with the effective date of 4/14/2003.

Printed Patient name:_____ **Date of Birth:** _____

Signature:_____ **Date:** _____

**** Please specify any persons you wish to release any information to, including:***

☐ Consent to order supplies (i.e. contacts lenses, glasses, prescription refills)

☐ Consent to make, cancel, and/or reschedule appointments

☐ Consent to release medical records or statements that include, but not limited to: RX information, referrals to specialists, etc.

I hereby authorize: _____(*relationship:*_____)

I hereby authorize: _____(*relationship:*_____)

******* *Please list any individuals / information you **DO NOT** want released:* _____

_____*******

Patient signature for release of information: _____ **Date:** _____

(By leaving this section blank, you are <u>NOT</u> giving consent for <u>ANYONE</u> to access <u>ANY</u> part of your medical records, including appointment times, billing, picking up supplies, etc.)

One Time Patient Authorization Form

I request that payment of authorized insurance companies (including, but not limited to: Medicare, Medigap*, Anthem, Aetna, and / or other insurances) be made on my behalf to Roxanne P. Metayer, OD of Windham, Maine for any services furnished to me by Dr. Metayer. I authorize any holder of medical information about me be released to the Center for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable for related services. If I have other health insurance coverage (as indicated in item 9 of CMS-1500 claim form or electronically submitted claim), my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above.

I understand that I am financially responsible for any co-payments and / or deductibles designated by my insurance company. I am aware that it is my responsibility to get any necessary referrals or prior authorizations before my scheduled visit. If I do not get a referral I realize that I may be asked to reschedule my appointment and / or will be financially responsible for the payment. Referrals do not guarantee coverage.

_____

Signature Date

**Medigap is the generic term for a Medicare beneficiary's supplemental insurance which is usually designed to provide benefits for the Medicare deductible and 20% coinsurance.*

Please bring a copy of your card(s) in with you to your appointment so we may verify and scan this information into your account.

Medical Coverage

Primary

Insurance Company Name: _____

Patient's Name *(as it appears on card):* _____

Member ID: _____

Claim mailing address:

Street address or PO Box: _____

City, State, Zip Code: _____

Secondary *(if applicable)*

Insurance Company Name: _____

Patient's Name *(as it appears on card):* _____

Member ID: _____

Claim mailing address:

Street address or PO Box: _____

City, State, Zip Code: _____

Vision Insurance Plan & Coverage
(if applicable)

Insurance Company Name: _____

Patient's Name *(as it appears on card):* _____

Member ID: _____