



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 ONE 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: <input type="checkbox"/> self	Strabismus: <input type="checkbox"/> self
Cataracts: <input type="checkbox"/> self	Amblyopia: <input type="checkbox"/> self
Macular degeneration: <input type="checkbox"/> self	Other condition / disease: <input type="checkbox"/> self
	specify: _____
Arthritis: <input type="checkbox"/> self	High cholesterol: <input type="checkbox"/> self
Asthma: <input type="checkbox"/> self	High blood pressure: <input type="checkbox"/> self
Diabetes: <input type="checkbox"/> self	Thyroid condition: <input type="checkbox"/> self
Cancer: <input type="checkbox"/> self	Other: <input type="checkbox"/> self
Heart disease: <input type="checkbox"/> self	specify: _____

FAMILY HISTORY

DOES ANYONE IN YOUR FAMILY (PARENTS/BROTHERS/SISTERS) HAVE ANY OF THE FOLLOWING? WHO?

<input type="checkbox"/> Glaucoma _____	<input type="checkbox"/> Diabetes _____
<input type="checkbox"/> Blindness _____	<input type="checkbox"/> Heart Disease _____
<input type="checkbox"/> Macular Degeneration _____	<input type="checkbox"/> 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	For research
To obtain payment for services	To avert a serious threat to health or safety
In emergency situations	For organ and tissue donation
For appointment and patient recall reminder	For workers' compensation programs
To efficiently co-manage patient care with specialists and primary care physicians	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 request restrictions
The right to amend	The right to a paper copy of this notice
The right to an accounting of disclosures	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 NOT giving consent for ANYONE to access ANY 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: _____