OPHTHALMOLOGY CONSULTANTS
OF FORT WAYNE, P.C.

TODAY'S DATE: _____, 20 ___

PATIENT INFORMATION (PLEASE PRINT)

NAME: LAST FIRST MI	***HOME TELEPHONE*** ( )	AGE	SEX	BIRTH DATE
ADDRESS	CITY	STATE	ZIP CODE	
MARITAL STATUS (CHECK ONE): ❒MARRIED ❒SINGLE ❒WIDOWED ❒SEPARATED ❒DIVORCED		NAME OF SPOUSE		
SOCIAL SECURITY NUMBER	EMPLOYER'S NAME			
EMPLOYER'S ADDRESS	***ALTERNATE TELEPHONE NUMBER*** ❒ Work ❒ Cell ( )			
REFERRING DOCTOR	FAMILY DOCTOR	STUDENT STATUS: ❒FULL TIME ❒PART TIME ❒N/A		

PLEASE PROVIDE INSURANCE CARD(S) TO BE COPIED AT TIME OF VISIT.
RESPONSIBLE PARTY / GUARDIAN (*IF APPLICABLE*)

NAME: LAST FIRST MI	RELATIONSHIP TO PATIENT	**HOME TELEPHONE** ( )
ADDRESS	CITY	STATE ZIP CODE
SOCIAL SECURITY NUMBER	EMPLOYER	***ALTERNATE TELEPHONE NUMBER*** ❒ Work ❒ Cell( )

INSURANCE INFORMATION

PRIMARY INSURANCE

NAME OF CARRIER	POLICY NUMBER	GROUP NUMBER
NAME OF INSURED AS IT APPEARS ON CARD	RELATIONSHIP TO PATIENT: ❒SELF ❒SPOUSE ❒PARENT ❒OTHER	**INSURED SOCIAL SECURITY NUMBER**
INSURED'S BIRTHDATE	***INSURED'S SEX***	INSURED'S EMPLOYER & ADDRESS

SECONDARY INSURANCE

NAME OF CARRIER	POLICY NUMBER	GROUP NUMBER
NAME OF INSURED AS IT APPEARS ON CARD	RELATIONSHIP TO PATIENT: ❒SELF ❒SPOUSE ❒PARENT ❒OTHER	**INSURED SOCIAL SECURITY NUMBER**
INSURED'S BIRTHDATE	***INSURED'S SEX***	INSURED'S EMPLOYER & ADDRESS

❒ **IF PATIENT HAS MORE THAN TWO INSURANCES, PLEASE CHECK HERE.**

HOW DO YOU PLAN TO PAY FOR TODAY'S SERVICES?

❒**CASH** ❒**CHECK** ❒**MASTERCARD** ❒**VISA** ❒**DISCOVER**

IN ORDER TO RELEASE INFORMATION REGARDING ANY INSURANCE CLAIM YOU MAY HAVE, PLEASE SIGN ON THE REVERSE SIDE.

ACCIDENT / INJURY INFORMATION			
ARE YOU BEING SEEN AS A RESULT OF AN INJURY? ☐YES ☐NO ☐WORK ☐AUTO ☐OTHER			
IF YES, DATE OF INJURY:			
WORKER'S COMPENSATION BILLING NAME, IF INJURY IS WORK RELATED:			
ADDRESS	CITY	STATE	ZIP CODE

I agree that I am responsible for payment for all services provided to me by Ophthalmology Consultants of Fort Wayne, P.C. ("OCFW"), subject to limitations set forth in any applicable insurance or other third-party benefits contract. I agree that I will pay all applicable insurance co-payments and deductibles. I further agree that I will pay all other outstanding balances for which I am responsible. For example, I will be responsible for any services: which Medicare, Medicaid, Medigap, or my insurance or other third-party benefits plan determines are not covered; for which the benefits have been exhausted; for which I fail to obtain any required authorization from my primary care physician; and, for which any spend down amount has not been met. I will also be responsible for any out-of-network fees and for any other amounts which are due and are not required to be written off by the contract OCFW has with my insurance or other third-party benefits carrier. I agree to pay such amounts within thirty (30) days of being notified by OCFW of the balance due. I understand that if I fail to pay my balance, my account may be turned over to a collection agency. In such an event, I agree that I will be responsible for all collection fees (including reasonable legal fees).

In the event I am eligible to receive benefits from Medicare, Medigap, Medicaid and/or any other insurance carrier for healthcare services provided to me by OCFW, I hereby assign to OCFW all rights I have to be reimbursed for medical expenses generated by OCFW with respect to Medicare, Medigap, Medicaid and/or any other insurance carrier, including any plan or policy of insurance (group or individual), flexible spending account, health savings account, health reimbursement arrangement or similar plan or reimbursement mechanism. This assignment includes all rights that I may have under the Employee Retirement Income Security Act of 1974, including, but not limited to, all rights concerning obtaining copies of plan/policy documents, rights to reasonable and customary fee schedules, and rights to appeal any full or partial claim denial for treatment by OCFW. In addition, I hereby request that payment of any authorized Medicare benefits, Medigap benefits, Medicaid benefits and/or insurance or other third-party benefits be made directly to OCFW. If said benefits are not paid directly to OCFW, I agree to forward to OCFW all payments that I receive immediately upon my receipt. To assist this process, I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, Indiana Health Coverage Programs/Medicaid and/or any other insurance or third-party payor and their respective agents any information needed to determine the benefits payable for the services rendered to me. Further, to the extent I have a worker's compensation claim, I authorize OCFW to release medical information regarding services provided by OCFW as a result of the worker's compensation injury that occurred on the ___ day of _____, 20__, to my employer upon my employer's request.

I certify that I understand and agree to comply with the financial responsibilities and assignment of benefits set forth above.

_____ _____

Printed Name of Patient or Responsible Party Date

_____

Signature of Patient or Responsible Party

OPHTHALMOLOGY CONSULTANTS MEDICAL HISTORY QUESTIONNAIRE

PATIENT NAME: _____ DATE: _____, 20____

WHO IS YOUR FAMILY PHYSICIAN (OR PRIMARY CARE PHYSICIAN)?: _____
WHO REFERRED YOU TO THIS OFFICE? _____

REASON FOR TODAY'S VISIT? _____

MEDICATION ALLERGIES AND REACTIONS:_____
Employer/Occupation:_____
IN CASE OF EMERGENCY, WHO SHOULD WE CONTACT? _____PHONE:_____

REVIEW OF SYSTEMS- DO YOU CURRENTLY HAVE OR HAVE YOU RECENTLY HAD ANY OF THE FOLLOWING?

SYSTEM	Yes/No	SYSTEM	Yes/No
Constitutional: Fever	□Yes □No	**Metabolic:** Intolerant to: □Heat □Cold	□Yes □No
Weight: □ Loss □ Gain	□Yes □No	**Endocrine:** Excessive Thirst	□Yes □No
Eyes: Double Vision	□Yes □No	Urinating more often	□Yes □No
Sensitivity to Light	□Yes □No	**Neurological:** Weakness	□Yes □No
Pain	□Yes □No	Headache	□Yes □No
Floaters	□Yes □No	Numbness of Extremities	□Yes □No
ENT: Hearing Loss	□Yes □No	**Psychiatric:** Depressed Mood	□Yes □No
Sinus Problems	□Yes □No	**Integumentary/Skin:**	
Sore throat	□Yes □No	Dry Skin	□Yes □No
Respiratory: Asthma	□Yes □No	Rash	□Yes □No
Cough	□Yes □No	**Musculoskeletal:** Arthritis	□Yes □No
Cardiovascular: Chest pressure or discomfort	□Yes □No	Joint Swelling	□Yes □No
Irregular Heartbeat/Palpitations	□Yes □No	**Hematologic/Lymphatic:**	
Gastrointestinal: Diarrhea	□Yes □No	Easily: □ Bleeds □Bruises	□Yes □No
Heartburn	□Yes □No	Swollen Lymph Nodes	□Yes □No
Vomiting	□Yes □No	**Allergic/Immunologic:**	
Genitourinary: Kidney Stones	□Yes □No	□ Environmental □ Food □Seasonal	□Yes □No

List all Prescribed and Over the Counter Medications, including vitamins and supplements you are currently taking:

Name of Medication	For what condition	Dosage	Frequency

Ocular History

Do you currently have, or have you ever had:	Yes/No	Eye	Diagnosis	Current Treatment/Previous Surgery	When?
Eye Disease	□Yes □No				
Eye Injury	□Yes □No				
Eye Surgery	□Yes □No				

Medical History

Do you now, or have you ever had:	Yes/No	Current Treatment/Previous Surgery	When?
Diabetes (Type)	□Yes □No		
Heart Disease	□Yes □No		
Pacemaker/Defibrillator □Yes □No			
High Blood Pressure	□Yes □No		
High Cholesterol	□Yes □No		
Kidney Failure (Dialysis □ Yes □ No)	□Yes □No		
Liver Disease	□Yes □No		
Stroke	□Yes □No		
Anemia	□Yes □No		
Thyroid Disease:	□Yes □No		
□Overactive □Underactive	□Yes □No		
Cancer or Tumor (Type)	□Yes □No		
Females: □ Pregnant □ Nursing	□Yes □No		
Other:	□Yes □No		

Family History: Relationship

□ Yes □ No High Blood Pressure _____
□ Yes □ No Diabetes _____
□ Yes □ No Cancer _____
□ Yes □ No Glaucoma _____
□ Yes □ No Cataracts _____
□ Yes □ No Retinal Disease _____
□ Yes □ No Other eye/medical Problems (please specify)_____

Social History:

Use of Tobacco: □ Current □ Former
□ Never Amt: _____
Alcohol: □ Yes □ No
Amount: _____
Drugs: □ Yes □ No

VISUAL FUNCTION QUESTIONS

Please check Yes or No if you are experiencing any difficulty with the following while wearing your glasses or contacts:

	Yes	No	Comments
Reading small print			
Reading newspaper or book			
Recognizing people when close			
Seeing steps, stairs or curbs			
Difficulty driving on bright sunny days			
Difficulty driving at night			
Reading traffic signs, street signs			
Doing fine handiwork			
Writing checks, completing forms			
Taking part in sports/hobbies/games			
Watching TV			
Bothered by glare/halos			

Patient's Signature:_____ Date: _____
Reviewed by: _____ Date: _____

SCOTT A. MILLER, MD
MARK A. RENSHAW, MD
JEFFREY D. HUDSON, MD
BRIAN C. MILLER, MD
PATRICK B. HOPEN, MD
DAWN FREDERICKSON, OD
JULIE A. MANRY, OD

OPHTHALMOLOGY CONSULTANTS
OF FORT WAYNE, P.C.

Eye M.D.s

MAIN OFFICE:
7232 Engle Road
Ft Wayne, IN 46804
(260) 436-7205
FAX: (260) 432-1339

NORTH OFFICE;
10186 E. Dupont Circle Dr
Ft Wayne, IN 46825

www.ophc.com

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT
(HIPAA) PRIVACY RECEIPT ACKNOWLEDGEMENT

I acknowledge that a copy of the (HIPAA) Notice of Privacy Practices has been provided to me by Ophthalmology Consultants of Ft. Wayne, P.C. and I understand that I have the right to review the Notice of Privacy Practices prior to signing this document. My signature acknowledges **only** that I have received or have been offered a copy of the (HIPAA) Notice of Privacy Practices.

Ophthalmology Consultants of Fort Wayne, P.C. reserves the right to change the privacy practices that are described in the (HIPAA) Notice of Privacy Practices.

_____
Printed Name of Patient

_____ _____
Signature of Patient Date of Birth

_____
Printed Name of Personal Representative

_____ _____
Signature of Personal Representative Date of Birth

_____
Description of Personal Representative's Authority

The above named patient or personal representative of the patient was given Ophthalmology Consultants of Fort Wayne, P.C's (HIPAA) Notice of Privacy Practices on the date indicated, but either refused to sign the acknowledgement or did not return the acknowledgement.

_____
Signature and Title of Person Providing the HIPAA Notice of Privacy Practices

CONSENT TO RELEASE INFORMATION: This consent form allows Ophthalmology Consultants of Fort Wayne, P.C. to use and disclose information about me protected under the Health Insurance Portability and Accountability Act (HIPAA) of 1996. I understand that by this consent, I am allowing Ophthalmology Consultants of Fort Wayne, P.C. to release my protected health information to the following individuals. I also understand that my health information is subject to verification of identity of the individual(s) I authorized prior to disclosure. Ophthalmology Consultants of Fort Wayne, P.C. is not responsible for any disclosures made by the following individuals:

Name	Relationship	Identifier (I.e. date of birth)

I understand that at any time I have the right to revoke this consent and that I must do so in writing, but that Ophthalmology Consultants of Fort Wayne, P.C. may still use information to complete any actions that it began prior to my revoking consent.

Patient's Printed Name: _____ Date: _____

Signature: _____