CONSULTING OPHTHALMOLOGISTS, P.C.
499 Farmington Avenue, Suite 100
Farmington, Connecticut 06032
295 Western Boulevard
Glastonbury, Connecticut 06033

Office Phone: (860) 678-0202 ✦ Fax: (860) 678-0224
www.consultingeye.com

Name_____ D.O.B _____
Last First M.I.
Address_____ City_____ State_____ Zip_____
Phone ( ) _____ Cell Phone ( ) _____ Email_____
Social Security #_____ Employer_____
Employer Address_____ City_____ State_____ Zip_____
Occupation_____ Marital Status: _____Married ___ Single ___Divorced ____Widow
Reason for my visit_____

EMERGENCY CONTACT INFORMATION

Name_____ Relationship_____
Address_____ City _____ State _____ Zip _____
Home Phone ( ) _____ Cell Phone ( ) _____

INSURANCE INFORMATION

Primary Insurance Co. _____ Policy Holder _____ D.O.B. _____
Primary Holders ID# or SS# _____ Group# _____ Employer_____
Secondary Insurance Co. _____ Policy Holder_____ D.O.B. _____
Primary Holders ID# or SS# _____ Group# _____ Employer_____

REFERRAL INFORMATION

Name of Referring Party_____ Phone ( ) _____
Name of Primary Care Physician _____Phone ( ) _____

FINANCIALLY RESPONSIBLE PARTY- *MUST BE COMPLETED IF PATIENT IS UNDER 18 OR A STUDENT.*

Name _____ Relationship_____ D.O.B._____
Address _____City_____ State_____ Zip_____
Phone ( ) _____ Cell Phone ( ) _____ Social Security # _____

AUTHORIZATION AND RELEASE: I hereby authorize payment directly to Consulting Ophthalmologists, P.C. of any medical benefits otherwise payable to me. I understand that I am financially responsible to the provider for charges not covered by this assignment. I authorize Consulting Ophthalmologists, P.C. to release any information requested to support my claim including information which constitutes a psychiatric communication and/or related to treatment of alcohol and drug abuse. If any disclosed information contains AIDS/HIV information, state law prohibits further disclosure without specific written consent.

FINANCIAL RESPONSIBILITY: This information is accurate and true to the best of my knowledge. I understand that I am responsible to pay for services rendered including reasonable attorney fees and cost of collection in the event of a default, a 20% collection fee will be added to your account if we transfer your account to an outside collection agency.

SELF-REFERRAL ACKNOWLEDGEMENT: I understand that if at any time my insurance does not cover my services, I agree to pay all charges.

_____ _____
Signature Date

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Patient Name:_____
Last Name First Name Middle Initial

Date of Birth: _____ **Birth State:**_____

GENDER (please circle one): Male Female

PRIMARY LANGUAGE (please circle one):

English Spanish Other (indicate) _____

ETHNICITY (please circle one):
American Indian/Alaskan
Asian
Black/African American
Native Hawaiian
Caucasian
Other
Decline to Answer

RACE: (please circle one):
Hispanic or Latino
NOT Hispanic or Latino
Unknown
Decline to Answer

WHY ARE WE ASKING ABOUT RACE, ETHNICITY AND PREFERRED LANGUAGE?

The federal government has required that doctors demonstrate "meaningful use" of their electronic health record by collecting and entering specific demographic data.

We are required to ask Preferred Language, Gender, Race and Ethnicity and Date of Birth. The responses have also been specified by the government; therefore, we have listed them on the forms exactly as the government has stated them.

Rationale: Data on disparities of care, especially in areas with a very diverse population and/or specific population health indicators, are critical for the government in its effort to address those disparities and improve the health care system for all Americans. The specific race and ethnicity codes should follow the current federal standards published by the Office of Management and Budget (OMB). Although the rule requires that the listed demographic elements be captured for each unique patient, it is certainly within the patient's right to decline to answer or not know the information. Preferred language captures a patient preference only; there is no requirement for the provider to actually communicate to the patient in that preferred language.

Thank you for assisting us in complying with this mandate.

Signature_____ Date:_____

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MEDICATION LIST _____
Last Name First Name

Pharmacy Name: _____

Pharmacy Phone:_____

MEDICATION ALLERGIES/REACTION:_____
_____
_____
_____

Medication	Dosage/Frequency	Start Date	End Date	Staff Comments	Staff Initials

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PATIENT MEDICAL HISTORY RECORD

_____ _____ Gender: ____M ____ F
PATIENT NAME (LAST, FIRST) BIRTHDATE (MM/DD/YY)

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

1. Have you ever been treated for any medical conditions (diabetes, high blood pressure, arthritis, pulmonary disease, bowel disorder, neurological disorder, rheumatologic disorder or malignancy etc.?)
   ❑Yes ❑No If yes, please explain: _____
   _____
2. Have you ever had any eye disease or injury (glaucoma, cataract, lazy eye, or retinal detachment)? ❑Yes ❑No If yes, please explain: _____ _____
3. Have you ever had surgery? ❑Yes ❑No If yes, please provide date(s) and procedure(s):_____
4. Have you ever been hospitalized? ❑Yes ❑No If yes, please provide date and reason: _____
5. Do you take any medications, for general health (including aspirin, vitamins and herbals)? ❑Yes ❑No If yes, please list: _____
   _____
6. Do you take any eye medications (including drops, ointments and pills)?
   ❑Yes ❑No If yes, please list:_____
7. 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:

Chronic fever, unexpected weight loss/gain, fatigue ❑ Yes ❑ No If yes, please explain: _____

Ear/nose/throat problems (hearing loss, sinus, sore throat) ❑ Yes ❑ No If yes, please explain:
_____

Heart problems (chest pain, irregular heartbeat) ❑ Yes ❑ No If yes, please explain:
_____

Respiratory problems (shortness of breath, wheezing, cough) ❑ Yes ❑ No If yes, please explain:
_____

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PATIENT MEDICAL HISTORY RECORD

Gastrointestinal problems (heartburn, belly pain, diarrhea, nausea) ❑ Yes ❑ No If yes, please explain:

_____

Urinary problems (pain, frequent urination, blood in urine) ❑ Yes ❑ No If yes, please explain:

_____

Skin problems (rashes, dermatitis, excessive dryness and itching) ❑ Yes ❑ No If yes, please explain:

_____

Musculoskeletal problems (muscle aches, joint pain or swelling) ❑ Yes ❑ No If yes, please explain:_____

_____

Neurological problems (numbness, weakness, headaches) ❑ Yes ❑ No If yes, please explain:_____

_____

Psychiatric problems (depression, anxiety, other) ❑ Yes ❑ No If yes, please explain:_____

_____

Endocrine problems (diabetes, thyroid) ❑ Yes ❑ No If yes, please explain:_____

_____

Blood Disorders (leukemia, other) ❑ Yes ❑ No If yes, please explain:_____

_____

Family and Social History

Do any medical or eye diseases run in your family (diabetes, high blood pressure, glaucoma, cataract, macular degeneration) ❑Yes ❑No If yes, please explain:

_____

Do you smoke? ❑Yes ❑No If yes, how much? _____

Do you drink alcohol? ❑Yes ❑No If yes, how much? _____

Do take any recreational drugs? ❑Yes ❑No

If YES, list what and how often? _____

Any other medical issues not addressed above?

_____

_____

_____ _____

Patient Signature Date

_____

MD Signature Date

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Authorization to Share Information

Patient Name: _____ Patient Date of Birth:

☐ **I do not wish to share my information with anyone at this time.**

_____ _____

Signature **Date**

☐ **I do wish to share my information with the following:**

With whom do you allow us to share your personal information?

Name: _____ Relationship: _____ Phone:

Name: _____ Relationship: _____ Phone:

Name: _____ Relationship: _____ Phone:

Please complete the following statements:

☐ **Y** ☐ **N** I authorize you to share my **appointment and demographic information** with the above individuals at my request.

☐ **Y** ☐ **N** I authorize disclosure of **personal medical information** with the above individuals (this includes information such as diagnosis, records, examination rendered, claims information and portal information) at my request.

☐ **Y** ☐ **N** I authorize the sharing of all **billing Information**

This agreement will remain in effect until terminated by me in writing without exception.

_____ _____

Signature Date

If the signing individual is not the individual that this agreement represents, please identify your authorization to represent (ex. Power of attorney).

I understand I can revoke this authorization at any time by providing written authorization to Consulting Ophthalmologists. I understand failure to authorize does not restrict from exceptions detailed in the Notice of Privacy Practices or HIPAA.

Revised 11-11-2019

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This document is to be signed by a person legally responsible for the patient's medical decisions relative to the treatment situation.

I, _____, hereby acknowledge that Consulting Ophthalmologists, P.C. has provided me with a copy of its Notice of Privacy Practices that describes how medical information about me may be used and disclosed, and how I can access this information. I understand that if I have questions or complaints I may contact:

Medical Records Coordinator/Privacy Officer
860-678-0202

I also understand that I am entitled to receive updates upon request if Consulting Ophthalmologists, P.C. amends or changes its Notice of Privacy Practices in a material way.

_____ _____
Signature — Relationship to Patient, if signed by someone other than the patient

_____
Date

THIS SECTION IS TO BE COMPLETED BY CONSULTING OPHTHALMOLOGISTS, P.C. IF UNABLE TO OBTAIN A WRITTEN ACKNOWLEDGEMENT FROM PATIENT.

I made a good faith effort to obtain a written acknowledgement of receipt of the Notice of Privacy Practices from the above named patient, but was unable to because:

- ❑ Patient declined to sign this Written Acknowledgement
- ❑ Other (specify):_____

_____ _____
Name and Title of Employee — Date