



CONSULTING OPHTHALMOLOGISTS, P.C.
499 Farmington Avenue, Suite 100
Farmington, Connecticut 06032

295 Western Boulevard
Glastonbury, Connecticut 06033

Office Phone: (860) 678-0202
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 MEDICAL HISTORY RECORD

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

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

M.D. Signature

Date

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WWW.CONSULTINGEYE.COM

MEDICATION LIST _____

Last Name

First Name

Pharmacy Name: _____

Pharmacy Phone: _____

MEDICATION ALLERGIES/REACTION: _____

[illegible]



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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.

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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