Medical History Questionnaire

Date _____

Name _____ **Birth Date** _____

Name of Family Doctor _____ **Referred By** _____

Review Of Symptoms

Do you have any problems in the following areas? Put **Y** if yes, **N** if no.

Constitutional Symptoms:

GENERAL

____ Fever
____ Fatigue
____ Weight Loss or Gain
____ Night Sweats

EYES

____ Loss of Vision
____ Blurred Vision
____ Double Vision
____ Dryness
____ Redness
____ Sandy or Gritty Feeling
____ Itching, Burning
____ Foreign Body Sensation
____ Excess Tearing / Watering
____ Glare / Light Sensitivity
____ Eye Pain or Soreness
____ Chronic Infection of Eye or Ld
____ Tired Eyes

ENT

____ Ears, Nose, Mouth, Throat
____ Sinus Infections / Allergies
____ Cough (Persistent)
____ Hearing Loss

HEART

____ Heart disease
____ Irregular Heart Beat
____ Heart Attack
____ High Blood Pressure
____ Pacemaker
____ Chest Pain
____ Mitral Valve Prolapse

LUNGS

____ Emphysema
____ Asthma
____ Chronic Bronchitis
____ Shortness of Breath
____ Bloody Sputum

GI / GU

____ Stomach
____ Intestinal Problems
____ Ulcers
____ Kidney
____ Bladder

MUSCULOSKELETAL

____ Muscle Pain
____ Joint Pain / Arthritis

INTEGUMENTARY

____ Skin Rashes
____ Breast Disease

NEUROLOGICAL

____ Headaches
____ Seizures
____ Stroke

PSYCHIATRIC

____ Depression
____ Anxiety
____ Psychiatric Problems

ENDOCRINE

____ Diabetes
____ Thyroid Disorders

HEMATOLOGIC / LYMPHATIC

____ Blood Disease
____ Lymph nodes
____ Anemia

ALLERGIC / IMMUNOLOIC

____ Head Allergy Symptoms
____ Seasonal Allergies
____ Hayfever Symptoms

ANYTHING INFECTIOUS

____ AIDS / HIV
____ TB
____ Hepatitis
____ Shingles
____ Other:
_____

OTHER

____ Pregnant

Reason For Eye Visit Today:

_____

_____

_____

STEVEN G. SAFRAN, M.D., PA

EYE PHYSICIAN & SURGEON

Ophthalmology
Cornea & External Disease

DIPLOMATE AMERICAN BOARD OF OPHTHALMOLOGY

At Steven G. Safran, M.D., P.A. we understand that communication is an important part of the patient/health care provider relationship. To ensure that we get important information to our patients in a timely manner, we often leave messages on voice mail, answering machines or with family members. In some cases, we may need to leave messages on voicemail or answering machines with details information regarding your condition or treatment. You should be aware that other individuals who have access to your voicemail or answering machine may hear these messages. At home, this may mean that members of your family may hear these messages. At work, it may mean that your employer may hear these messages.

Please let us know on what numbers we may leave detailed or brief messages.

_____ * Detailed * Brief
Home

_____ * Detailed * Brief
Cell

_____ * Detailed *Brief
Work

You may also designate two people with whom we may discuss your condition and treatment.

_____ _____ _____
Name Relationship Last 4 of SS# or DOB (Required)

_____ _____ _____
Name Relationship Last 4 of SS# or DOB (Required)

Your e-mail address:_____

By signing below, I acknowledge that I have read and understand the Privacy Practives for Steven G. Safran, M.D., P.A. I understand that Steve G. Safran, M.D., P.A. will not share my name or private information with any outside companies. I am aware that my information may be shared with my insurance company in order to have claims processed.

_____ _____
Patient Name Date of Birth

_____ _____
Patient Signature Today's Date

132 Franklin Corner Road, Suite A-1 • Lawrenceville, New Jersey 08648
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NEW PATIENT REGISTRATION FORM

PATIENT INFORMATION- PLEASE PRINT

LAST NAME_____FIRST NAME_____MI_____

MR./MRS./MS./DR. PLEASE CIRCLE ONE DATE OF BIRTH_____GENDER_____

ADDRESS_____APT#_____ CITY_____

STATE_____ZIP CODE_____EMAIL_____

HOME PHONE ( )_____CELL PHONE ( ) _____

WORK PHONE ( )_____SOCIAL SECURITY # _____

PHARMACY INFORMATION

PHARMACY NAME_____PHONE_____

ADDRESS _____

REFERRAL INFORMATION

REFERRING PHYSICIAN_____PHONE_____

PRIMARY PHYSICIAN_____PHONE_____

IN CASE OF EMERGENCY INFORMATION

NAME_____RELATIONSHIP TO PATIENT_____

HOME PHONE_____CELL PHONE_____

INSURANCE INFORMATION- OFFICE WILL COPY YOUR CARD UPON ARRIVAL

PRIMARY INSURANCE_____POLICY #_____

SECONDARY INSURANCE_____POLICY #_____

SUBSCRIBER'S DATE OF BIRTH_____RELATIONSHIP_____

THE ABOVE INFORMATION IS TRUE TO BEST OF MY KNOWLEDGE.

PATIENT SIGNATURE_____DATE_____

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INSURANCE AUTHORIZATION AND ASSIGNMENT

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance with our office biller.

I request that payment of authorized Medicare/Other Insurance company benefits be made on my behalf to Steven G. Safran, M.D., for any services furnished me by that party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this related Medicare claim/Other Medical Insurance claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. Section1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.

Patient Signature_____Date_____

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STEVEN G SAFRAN MD

OUR FINANCIAL POLICY

We are committed to providing you with the highest level of service and quality care. If you have medical insurance, we will strive to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our financial policy. Ultimately, however, any and all financial liability rests with the patient.

Our office participates with most major insurance plans. We provide **MEDICAL and SURGICAL** ophthalmologic care to our patients, as opposed to **routine eye exams**. We do not participate with **ANY** vision plans (VSP/Davis Vision, etc.). **If you have a managed care plan that requires a referral to see a specialist, you must obtain a referral in order for your visit in our office to be covered under your medical insurance.** If you do not have the valid referral and still wish to be seen, you will be asked to pay for the visit prior to your examination. **A refractive examination is not a covered service by most insurance companies including Medicare. If you receive a prescription for glasses, you will be charged $40 which is payable at the time of the visit.**

It is the patient's/parent's/guardian's responsibility to:

- Be familiar with the benefits of your plan, including co-pays, co-insurance and deductibles.
- Bring all of your current insurance cards to all visits.
- Provide our office with current information including address, phone numbers and employer.
- In accordance with your insurance contract, you must be prepared to pay your co-pay at each visit. If you do not make your co-payment at the time of the visit, you will be charged an additional **$10.00 billing fee**. We accept cash, checks and most major credit cards for services.

We appreciate prompt payment in full for any outstanding balance. If you are unable to pay a balance in full, please notify our billing department immediately and we will try to work out a payment plan with you. Any payment made by check that does not clear your bank account will result in a $25.00 fee, which will be added to your account and must be paid before the next visit.

For all services rendered to minor/dependent patients, we will look to the adult accompanying the patient and/or the parent or guardian with whom the child resides for payment. In cases of separation or divorce, when presenting insurance cards for a dependent enrolled under a subscriber other than you, please be prepared to supply their name, address, phone number, date of birth and social security number. We request that you inform the subscriber that their insurance has been used.

Any patient who cancels a scheduled surgery, or does not show up for surgery, will be charged a cancellation fee of $25.00. Legitimate emergencies will be taken into consideration.

I have read and understand the above financial policy.

_____ _____

Signature of patient/guardian/parent Date

_____ _____

Printed name of patient Date

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PATIENT NAME_____

NOTICE OF NON-COVERED SERVICE – REFRACTION

A REFRACTION IS AN ERROR IN THE FOCUSING OF LIGHT BY THE EYE AND A FREQUENT REASON FOR REDUCED VISUAL ACUITY. REFRACTION IS THE PROCESS USED TO DETERMINE THE EYE'S REFRACTIVE ERROR. REFRACTION IS AN ESSENTIAL PART OF A COMPREHENSIVE EYE EXAMINATION, BUT IT IS **NOT** A COVERED BENEFIT WITH MEDICARE OR MOST OTHER INSURANCE PLANS.

THE FEE FOR A REFRACTION IS $40.00. THIS FEE WILL BE COLLECTED IN ADDITION TO ANY CO-PAYMENTS AT THE TIME OF SERVICE.

ACKNOWLEDGEMENT

I HAVE READ THE ABOVE INFORMATION AND UNDERSTAND THAT THE REFRACTION IS A NON-COVERED SERVICE. I ACCEPT FULL FINANCIAL RESPONSIBILITY FOR THE COST OF THE REFRACTION. I FURTHER UNDERSTAND THAT ANY C0-PAYMENTS AND OR DEDUCTIBLES UNDER MY PLAN ARE SEPARATE FROM AND NOT INCLUDED IN THE REFRACTION.

PATIENT SIGNATURE:_____

DATE:_____

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