PATIENT INFORMATION

Name: Mr. Mrs. Ms_____ Date: _____

Address: _____ City_____ Zip_____

Home Phone: _____ Cell Phone _____ Social Security _____

Date of Birth: _____ Age: _____ Sex: □ M □ F

Employer's Name: _____ Business Phone: _____

Employer's Address: _____Zip_____

Spouse's Name: _____ Spouse's Date of Birth _____

Spouse's Employer: _____ Business Phone: _____

MEDICAL INSURANCE INFROMATION

Medicare Number_____ Medicaid Number_____

Insurance Carrier_____ Policy Number: _____

2nd Insurance_____ Policy Number_____

INSURED INFORMATION

Name: _____ Relationship: _____

Date of Birth _____ Social Security # _____

Address: _____ Zip: _____ Phone: _____

Employer's Name: _____Business Phone: _____

Employer's Address: _____Zip: _____

EMERGENCY CONTACT (OTHER THAN SPOUSE)

Name: _____ Relationship: _____

Address: _____Zip_____ Phone: _____

IF INJURY, IS IT WORK RELATED? Yes_____ No_____

If yes give date of injury_____

Name of person to contact for verification_____

Address: _____ Phone: _____

Medical Information

Date:_____ Referred by:_____

Name:_____ Family Physician:_____

1) Medication Allergies and Reactions/Severity:

Example: Penicillin - Rash / mild

2) Past Medical / Surgical History:

3) Current Medications (Include any over the counter and/ or herbal medications):

Name	Dosage/ mg	Name	Dosage/ mg

Do you take Aspirin, Ibuprofen, or any blood thinners? If so, please specify. _____

Heritage Eye Center

Patient Name _____ Date _____

Place a check mark by all that apply.

Review of Systems:

CONSTITUTIONAL

Normal
Fever
Weight Loss
Other _____

EYES

Normal
Blurred Vision
Double Vision
Pain
Discharge
Other _____

EARS, NOSE, MOUTH THROAT

Normal
Pain
Mass
Discharge
Hearing Loss
Smell
Other _____

CARDIOVASCULAR

Normal
Chest Pain
Shortness of Breath
Irregular Heart Beat
Other _____

RESPIRATORY

Normal
Shortness of Breath
Cough
Asthma
Other _____

GASTROINTESTINAL

Normal
Bowel Habits/Change
Diarrhea
Constipation
Stomach Pain
Ulcers
Other _____

HEMATOLOGIC/LYMPHATIC

Normal
Anemia
Blood Disease
Free Bleeder
Swollen Lymph Nodes
Other _____

MUSCULOSKELETAL

Normal
Weakness
Joint Pain
Decreased ROM
Other _____

INTEGUMENTATRY (SKIN/ BREAST)

Normal
Masses
Tumors
Pigmented Lesions
Rash
Other _____

NEUROLOGIC

Normal
Weakness
Tingling
Numbness
Other _____

FAMILY HISTORY:

Cataracts _____

Glaucoma _____

Retinal Detachments:

_____

Eye Disorders:

_____

Diabetes _____

High BP _____

Heart Disease _____

Other _____

SOCIAL HISTORY:

Drugs _____

Alcohol _____

Smoke _____

Do you live with:

Alone

With Spouse

Other _____

HERITAGE EYE CENTER

RUDOLF CHURNER, M.D. **SANJAY PATEL, M.D.**
JAMES NORBURY, JR., M.D. **GRANT GILLILAND, M.D.**
JOSPEH CONSTABLE, O.D.

Heritage Eye Center
1501 N. Redbud Blvd.
McKinney, TX 75069
Phone: 972-548-0771
Fax: 972-562-2300

Allen Ophthalmology
400 N. Allen Dr., # 108
Allen, TX 75013
Phone: 972-727-7477

Welcome to the Heritage Eye Center & Allen Ophthalmology (physician owned facilities). Please read each of the following policies and initial each paragraph and sign below.

Acknowledgment of Notice of Privacy Practices

_____ I have been given the opportunity to review the Notice of Privacy Practices and Policies for Identity Protection for the Heritage Eye Center/Allen Ophthalmology which explains how my medical information will be used and disclosed and how my personal and financial information will be handled. I understand that I am entitled to receive a copy of these documents upon request.

Patient Bill of Rights

_____I have been given a copy of the Patient Bill of Rights and as a patient; I understand the policies which give me the right to choose my physician, my course of treatment, and my responsibilities as a patient at the Heritage Eye Center/Allen Ophthalmology. I also understand the center's grievance policy should I not be pleased with any aspect of my service at the center.

Advanced Medical Directives/Medical Power of Attorney

_____I understand that it is my right to execute a Medical Power of Attorney (a document appointing someone to make medical decisions for me in the event that I become incapacitated). I understand that upon request, the center will provide a copy of the official state regulated Medical Power of Attorney form. I also understand that if I have executed a Medical Power of Attorney or wish to do so, I must provide a copy of the completed form prior to any procedure performed at the center.

Refraction Policy & Acknowledgment

Refraction is the process of determining the eye's refractive error, or need for corrective spectacle lenses (glasses). Refraction is part of an eye exam but is NOT a covered service by Medicare or most managed care plans. Our office fee for the results of refraction (glasses prescription) is **$40.00**. This refraction fee is in addition to the patient's co-pay.

_____I have read the above statement and understand that refraction is a non-covered service. I accept full financial responsibility for the cost of the service. The co-pay is separate from and not included in the refraction fee.

_____ _____
Signature of Patient or Representative Date

_____ _____
Printed Name of Patient or Representative Representative's Relation to Patient

(Revised 6/2015)

HERITAGE EYE CENTER
INSURANCE PAYMENT AUTHORIZATION
SIGNATURE ON FILE

1. MEDICARE

I request that payment of authorized Medicare benefits be made on my behalf to Heritage Eye Center, for services furnished me by Heritage Eye Center. I authorize any holder of medical information about me to release to the Heritage Eye Center Financing Administration and its agents and information needed to determine these benefits of the payable to relate services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on the other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown.

Heritage Eye Center accepts the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____
Signature Date

2. MEDIGAP

If a Medigap policy or other health insurance is indicated in tIten 9 of HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made either to me or on my behalf to Heritage Eye Center.

_____ _____
Signature Date

3. OTHER INSURANCE

I herby authorize payment of my medical and surgical insurance benefits to Heritage Eye Center. I understand I am financially responsible for any charges whether or not paid by said insurance. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Heritage Eye Center. I authorize Heritage Eye Center to release any information required to process any and all claims for reimbursement on my behalf. A copy of this authorization may be used in place of the original.

_____ _____
Signature Date

HERITAGE EYE CENTER
1501 Redbud Blvd.
McKinney, TX 75069

REFRACTION

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ACKNOWLEDGEMENT

I have read the above statement and understand that refraction is a non-covered service. I accept full financial responsibility for the cost of the service. I also understand that the copay is separate from and not included in the refraction fee.

_____ _____

Signature Date

HERITAGE EYE CENTER

AUTHORIZATION TO RELEASE PATIENT INFORMATION

Keeping our patient's information private is important to us and by default we will only disclose information related to the patient's **Billing Account** and **Medical Treatment** to the patient or legal guardian.

If you would like additional contacts (other than the patient or legal guardian) to receive information regarding your medical treatment and/or billing information, please complete the fields below.

Name	Relationship to Patient
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____

Signature Date