



PATIENT INFORMATION

Chart Number _____

PLEASE PRINT

Today's Date _____

Patient's Name _____
Last Name First Name MI.

Spouse's Name _____

Sex _____ **Birthdate** _____
M / F Month - Day - Year

SS# _____ - _____ - _____

Permanent Mailing Address _____
Street

City _____ **State** _____ **ZIP** _____ **Home Phone** (____) _____

2nd Address _____ **Email** _____
Street We will not share your email with 3rd parties unless you request it

City _____ **State** _____ **ZIP** _____ **Phone** (____) _____

Employer _____ **Phone** (____) _____

Employer's Address _____

In Case of Emergency

Nearest Relative or Friend/Guardian _____ **Phone** (____) _____

Relationship to Patient _____

Primary Care Physician _____

Previous History of Eye Treatment or Exams:

Any Family History of Eye Disease or Eye Surgery:

What problems are you having with your eyes? _____

Referred or recommended by _____

Thank you for choosing The Macula Center and Dana M. Deupree, M.D



MEDICAL HISTORY AND REVIEW FORM

FILE NO: _____

NAME: _____ PHONE: (____) _____ TODAY'S DATE: _____

FAMILY PHYSICIAN: _____ PHONE: (____) _____

PHARMACY: NAME: _____ PHONE: (____) _____

EMERGENCY CONTACT NAME: _____ PHONE: (____) _____

EMAIL ADDRESS: _____

PAST MEDICAL HISTORY: Please check if YES for each of the following:

- | | | | |
|---|---|--|----------------------------|
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Diabetes | _____ AGE |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Angina | <input type="checkbox"/> Liver Disease | _____ MALE |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Hepatitis | _____ FEMALE |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Kidney Disease | _____ DATE OF BIRTH: _____ |
| <input type="checkbox"/> Emphysema/COPD | <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Hiatal Hernia | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Stroke | <input type="checkbox"/> Ulcers | |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Claustrophobia | <input type="checkbox"/> Phlebitis | |
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Psychiatric Disorder | <input type="checkbox"/> Anemia | |
| <input type="checkbox"/> Carotid Artery Disease | <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Arthritis | |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Seizures | <input type="checkbox"/> Diverticulosis | |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> Rheumatoid Arthritis | |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Radiation/Chemo | <input type="checkbox"/> Lupus | |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Diabetes Type I/Type II | |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Parkinson's disease | |
| <input type="checkbox"/> Sickle Cell Disease | <input type="checkbox"/> Temporal Arteritis | <input type="checkbox"/> Other | |

Have you or a family member been diagnosed with the following?
Check if YES

- Creutzfeldt-Jakob Disease
- Gerstmann-Straussler-Scheinker Disease
- Fatal Familial Insomnia
- Have you received hormone injections to increase your height?

SOCIAL HISTORY: Occupation: _____
 Do you smoke? **NON-SMOKER EX-SMOKER SMOKER**
 Do you drink alcohol? **NONE OCCASION 1-2DAILY 3-4DAILY**
 Substance abuse? **NONE IVDA UNKNOWN**
 Marital status: **MARRIED SINGLE DIVORCED WIDOWED**

HOSPITALIZATIONS/SURGERY: List any previous below:

Surgery	Date
Thyroid/Neck	_____
Heart	_____
Lung	_____
Stomach/Abdomen	_____
Cancer	_____
Other	_____

FAMILY HISTORY: How related
 Diabetes _____ Cancer _____
 High Blood Pressure _____ Stroke _____
 Heart Disease _____
 Ocular Disease – Macular degeneration _____
 Glaucoma _____ Retinal Detachment _____
 Blindness _____
 Other _____

ALLERGIES TO MEDICATIONS:

NO KNOWN ALLERGIES LATEX SENSITIVITY

***** PRESCRIPTION/NON-PRESCRIPTION MEDS: *****

Review of Systems: Do you have these now? If YES, explain:
NO YES

- Fever/Weight loss/Fatigue/Loss of appetite _____
- Hearing Loss/Sore Throat _____
- Chest Pain/ Shortness of Breath _____
- Wheezing/Cough _____
- Excess Thirst/Excessive Urination _____
- Heat Intolerance/Cold Intolerance _____
- Abdominal Pain/Nausea _____

- NO YES
- Pain/Burning on urination/Blood in Urine _____
 - Rash/Change in Mole _____
 - Swelling in the Feet _____
 - Muscle Aches/ Joint Pain/ Difficulty Lying Flat _____
 - Headaches/Scalp Tenderness/Tremor _____
 - Easy Bruising/Prolonged Bleeding _____

FOR OFFICE USE ONLY: REFERRING DOCTOR:

NAME _____ PHONE (____) _____ ADDRESS: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse To Sign This Acknowledgement

I, _____, have received a copy of
(Print Name)

this Office's Notice of Privacy Practices.

(Please Print Name)

(Signature)

(Date)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)



RECORDS RELEASE AUTHORIZATION

I HEREBY AUTHORIZE AND REQUEST THE RELEASE OF MY COMPLETE MEDICAL RECORD TO BE RELEASED FROM:

Name of Doctor / Hospital / Clinic

Address City State ZIP

Telephone Number

FAX

SEND TO:

Name of Doctor / Hospital/ Clinic

Address City State ZIP

Telephone Number

FAX

Patient Signature X _____ Date _____

PRINT: Patient Name _____ S.S.# _____

Patient Address _____

Telephone _____ Date of Birth _____

Chart Number _____

Witness Signature _____ Date _____



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Patient History Update Form

Patient name _____ **Chart #** _____ **Date** _____

	No update (✓)	Updated (new) information
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Name _____

Address _____

Email _____

Race White | Hispanic/Latino | Black/African American | Am. Indian
Asian or Pacific Islander | Middle Eastern | Hawaiian | Decline

Ethnicity _____ θ Of Hispanic origin θ NOT of Hispanic origin

Pharmacy name/address/ph _____

Past Medical history _____

Past Surgical history _____

Smoking _____

Alcohol consumption _____

Other drugs _____

New allergies to meds _____

Prescription changes _____



HIPAA Patient Questionnaire

1. Please list the family members or other person(s), if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations):

Name _____ Phone Number: _____
Name _____ Phone Number: _____
Name _____ Phone Number: _____
Name _____ Phone Number: _____

2. Please list the family members or others, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY.**

Name _____ Phone Number: _____
Name _____ Phone Number: _____
Name _____ Phone Number: _____
Name _____ Phone Number: _____

3. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent ***if other than your home. (Confidential Communications)***

4. Please indicate if you want all correspondence from our office sent in a sealed envelope marked **"CONFIDENTIAL"**: Yes: No:

5. Please print the telephone number or email address where you want to receive calls about your appointments, test results or other health care information if other than your home phone number:

Phone: (____) _____ Email Address: _____@_____

6. Can confidential messages (ie., appointment reminders) be left on your telephone answering machine or voicemail? Yes: _____ No: _____

7. I understand the Privacy Protection Act and have been offered a copy of the Organization's Notice of Privacy Practices updated for the HITECH Omnibus Rule of 2013.

PATIENT NAME: _____ (guardian if under 18 years)

PATIENT/GUARDIAN SIGNATURE DATE

DATE

THE MACULA CENTER FINANCIAL POLICY

Thank you for choosing The Macula Center as your health care provider. We are committed to your visit being successful on all levels. Because healthcare reimbursement is a complex and sometimes complicated system, we need your help to ensure your insurance benefits are maximized. The following is a statement of our Financial Policy which you will need to read and sign prior to any services. We also require all patients to give us complete demographic and insurance information prior to or upon arrival at our office.

For patients with insurance coverage, including Medicare

We accept assignment of insurance benefits. We will file a claim with your insurance company for any services you receive. The balance of your account after insurance pays is your responsibility. We cannot bill your insurance company without your insurance information and a copy of your insurance card(s): You are responsible to inform us if you have more than one insurance carrier and which carrier is primary and which is secondary. Your insurance policy is a contract between you and your insurance company. If your insurance company has not paid your account in full within 60 days of the date of service, the balance will be automatically transferred to you.

Each insurance plan has different policies regarding how often services may be rendered and, more importantly, where those services may be performed. Even within the same insurance company, plans can offer different benefits, depending on what your employer has negotiated. We strongly urge you to be familiar with your policy benefits.

Patient Responsibility

All co-pays required by your insurance company must be paid at the time of service. This payment is a requirement by your insurance company. Our office policy allows us to also collect co-insurance, and or deductible amounts at the time of service. All co-insurance and deductible amounts must be paid within 30 days of your insurance payment or determination of benefits from your insurance carrier. If your insurance coverage changes for any reason, it is your responsibility to inform our office and to provide any new insurance information along with a copy of your new card.

For patients with no insurance coverage

If you do not have insurance coverage, payment for services is expected at the time services are rendered.

For patients under Workers' Compensation

We accept assignment of insurance benefits for patients covered under workers' compensation. We will schedule an appointment after being notified from your employer or workers' compensation company. They will provide a claim number and address where to file the claim. The Insurance information and the contact to call to obtain authorization for services is necessary prior to your visit. You are responsible to inform us if your visit is related to a workers' compensation injury.

Patients involved in an automobile or other accident

We accept assignment of insurance benefits for patients involved in an auto accident upon doctor's approval. If it is approved, we will need the claim number, date of accident and address for the claims department before scheduling an appointment. We will file a claim with your auto insurance company for any services you receive. It is your health insurance company's responsibility to subrogate the claim with your auto insurance or any other party responsible for the accident.

We cannot bill the insurance company unless you give us the insurance information and a copy of your insurance card(s). You are responsible to inform us if your visit is related to an auto accident. The balance of your account is your responsibility regardless of payment from your insurance carrier. Your insurance policy is a contract between you and the insurance company. If your insurance company has not paid your account in full within 90 days from the date of service, the balance will be automatically transferred to you. We will not accept assignment from any other third party in relation to an automobile accident.

When all auto benefits are exhausted, we will file claims with your health insurance. If you are not insured, you will be responsible for all charges at the time of service.

Contact Information

Following your visit to the office we will file a claim with your insurance company if you have coverage. After we have received payment from your insurance company you may receive a statement showing any balance due from you. This amount is your responsibility and is due within 30 days of the statement date. We accept cash, checks, Visa, MasterCard, Discover American Express and Care Credit. If you have any questions regarding the balance on your account, please call our business office at 727-789-8770.

Patient name

Signature of Patient or Responsible Party

Date

COMMERCIAL INSURANCE

I authorize The Macula Center., to release to my health insurance company, any information needed to determine benefits for services or related services. I permit a copy of this authorization to be used in place of the original. I also request that payment of authorized benefits be made on my behalf to The Macula Center.

Patient name

Chart #

MEDICARE

I authorize The Macula Center to release to Medicare and its agents, any information needed to determine benefits for services or related services. I permit a copy of this authorization to be used in place of the original. I also request that payment of authorized benefits be made on my behalf to The Macula Center.

Patient name

Chart #

MEDIGAP (Medicare Supplemental Policies)

I request payment of authorized Medigap benefits be made on my behalf to The Macula Center, for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release to my Medigap insurer any information needed to determine these benefits.

Patient name

Chart #

Worker's Compensation

I request payment of authorized Worker's Compensation benefits be made on my behalf to The Macula Center for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release to my Worker's Compensation insurer any information needed to determine these benefits.

Patient name

Chart #

AUTO INSURANCE

I authorize The Macula Center., to release to my auto insurance company, any information needed to determine benefits for services or related services. I permit a copy of this authorization to be used in place of the original. I also request that payment of authorized benefits be made on my behalf to The Macula Center.

Patient name

Chart #