The Macula Center
Dana M. Deupree, M.D., F.A.C.S.

PATIENT INFORMATION Chart Number_____

PLEASE PRINT

Today's Date _____

Patient's Name _____ Spouse's Name _____
Last Name First Name MI.

SS Number _____

Sex _____ Birthdate ____ / ____ / ____ Pharmacy _____
M / F

Race ___ White ___ Hisp/Latino ___ Black/African Am ___ Am Indian

E-Mail _____
We will not share your e-mail with 3rd parties.

___ Asian/Pacific Islander ___ Middle Eastern ___ Hawaiian ___ Decline

Permanent Mailing Address _____
Street

City _____ State _____ Zip _____ Phone ( ) _____

2nd Address _____
Street

City _____ State _____ Zip _____ Phone ( ) _____

Employer _____ Phone ( ) _____

Employer Address _____

Primary Care Physician _____

How did you hear about us? Referred or recommended by _____

The Macula Center
Dana M. Deupree, M.D., F.A.C.S.

MEDICAL HISTORY AND REVIEW FORM

PATIENT NAME: _____ **DOB:** ____ / ____ / ____ **TODAY'S DATE:** _____

PAST MEDICAL HISTORY: Please check/indicate below ☐ if Applicable:
Please mark here ☐ if Not Applicable

☐Rheumatic Fever	☐Heart Disease	☐Diabetes Type I/Type II	☐Pneumonia
☐Angina	☐Liver Disease	☐Tuberculosis	☐Irregular Heartbeat
☐Hepatitis	☐Asthma	☐Heart Attack	☐Kidney Disease
☐Emphysema/COPD	☐Congestive Heart Failure	☐Hiatal Hernia	☐Cancer
☐Stroke	☐Ulcers	☐High Blood Pressure	☐Claustrophobia
☐Phlebitis	☐Bleeding Problems	☐Psychiatric Disorder	☐Anemia
☐Carotid Artery Disease	☐Alzheimer's	☐Arthritis	☐Thyroid Disease
☐Seizures	☐Diverticulosis	☐AIDS	☐Lyme Disease
☐Rheumatoid Arthritis	☐Migraines	☐Radiation/Chemo	☐Lupus
☐High Cholesterol	☐Meningitis	☐Multiple Sclerosis	☐Sleep Apnea
☐Parkinson's Disease	☐Sickle Cell Disease	☐Temporal Arteritis	☐Other _____

Have you/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
Alcoholic consumption? No, Occasionally 1-2 Daily, 3-4 Daily
Substance abuse? No, Ivda, Unknown
Marital status: Single, Married, 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 SENSITITIVTY ❑

PRESCRIPTION/ NON-PRESCRIPTION MEDICATIONS:

_____
_____
_____
_____
_____
_____
_____

REASON FOR VISIT/EYE SYMPTOMS:

_____

Review of Systems: Do you have these now? If YES, explain:

NO YES	NO YES	NO YES
___ ___ Fever/Weight loss/Fatigue/Loss of appetite	___ ___ Pain/Burning urination/Blood in Urine	___ ___ Swelling in the Feet
___ ___ Hearing Loss/Sore Throat	___ ___ Wheezing/Cough	___ ___ Rash/Change in Mole
___ ___ Chest Pain/Shortness of Breath	___ ___ Excess Thirst/Excessive Urination	___ ___ Swelling in the Feet
___ ___ Heat Intolerance/Cold Intolerance	___ ___ Headaches/Scalp Tenderness/Tremor	___ ___ Loss/Sore Throat
___ ___ Muscle Aches/Joint Pain/Difficulty Lying Flat	___ ___ Easy Bruising/Prolonged Bleeding	___ ___ Abdominal Pain/Nausea

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 diagnoses (including treatment, payment, and health care operations):

   Please mark here ☐ if NONE

Name _____ Relationship: _____ Phone: _____

Name _____ Relationship: _____ Phone: _____

Name _____ Relationship: _____ Phone: _____

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

   Please mark here ☐ if NONE

Name _____ Relationship: _____ Phone: _____

Name _____ Relationship: _____ Phone: _____

Name _____ Relationship: _____ Phone: _____

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

4. Can confidential messages (i.e., appointment reminders) ne left on your telephone answering machine or voicemail? Yes: _____ No: _____

5. I understand the Privacy Practice 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 of age)

_____ _____

Patient/guardian signature DATE

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of this Office's
(PRINT NAME)

Notice of Privacy Practices.

_____
(PLEASE PRINT NAME)

_____
(SIGNATURE)

_____
(DATE)

For Office Use Only

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

___ Individual refuse to sign

___ Communication barriers prohibited obtaining the acknowledgment

___ An emergency situation prevented us from obtaining acknowledgment

___ Other (Please specify)

_____

_____

THE MACULA CENTER FINANCIAL POLICY

Thank you for choosing The Macula Center as your healthcare provider. We are committed to your visits 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 demographics 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 automatically be 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 collect co-insurance, and or deductible amounts at time of service. All coinsurance 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's 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 don't 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's 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 on 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 automatically transferred to you. We will not accept assignment from any other third party on relation to an automobile accident. When all auto benefits are exhausted, we will file a claim with your health insurance. If you are not insured, you will be responsible for all charges at the time of service.

NO-SHOW POLICY

It is our practice policy to request that all patients provide a 24-48 hours advance notice prior to changing, rescheduling and/or cancelling their appointment(s). Failure to comply with this policy will result in a $25.00 no-show fee charge to your account.

CONTACT INFORMATION

Following your visit, we will file a claim with your insurance company, if applicable. After payment is received, 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 DOB

_____ _____

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 service 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 DOB

_____ _____

Signature of Patient or Responsible Party Date

MEDICARE

I authorize The Macula Center to release to Medicare and its agents any information needed to determine benefits for service 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 DOB

_____ _____

Signature of Patient or Responsible Party Date

MEDIGAP (Medicare Supplement 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 DOB

_____ _____

Signature of Patient or Responsible Party Date

WORKER'S COMPENSATION

I request payment of authorized Worker's Compensation benefits be made on my behalf to The Macula Center for any service 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	DOB
Signature of Patient or Responsible Party	Date

AUTO INSURNACE

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	DOB
Signature of Patient or Responsible Party	Date

Completed new patient paperwork can be submitted as followed:

E-mail to: MaculaCenter@vip-us.net

Completed through the **patient portal:**
https://promptlybyfph.com/promptly/webapp/#/

Fax to: (727) 789-8784

Mail to: The Macula Center, 3280 N. McMullen Bth Rd, Ste 120 Clearwater, FL 33761

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