MEDICAL HISTORY QUESTIONNAIRE FOR EYE PHYSICIANS OF LANCASTER

Name: _____ **Primary reason for today's visit:** _____

Where you referred here by another physician? Please list physician's name:_____

Please circle the following symptoms you are experiencing with your eyes, and specify which eye(s). Please elaborate next to each symptom if needed:

Symptom	Notes
Loss or blurred vision	
Loss of side/peripheral vision	
Double vision	
Glare/Halos	
Light Sensitivity	
Flashes of Light	
Floaters/Black Spots/Black Specks	
Dryness	
Tearing/Wateriness	
Itching	
Redness	
Burning	
Discharge	
Gritty feeling	
Eye pain or soreness	
Infection of eye lashes or lids; styes	
Other:	
Other:	
Other:	
Other:	
Other:	

1. Do you wear (circle):
    i. Glasses *and* contact lenses
    ii. Only glasses
    iii. Only contact lenses
    iv. None

2. Please circle any condition <u>you</u> have presently or have had in the past:
   a. Dry Eyes
   b. Cataract
   c. Macular Degeneration
   d. Retinal Detachment
   e. Glaucoma
   f. Keratoconus
   g. Other (please list):

_____

_____

_____

3. Please circle any condition <u>your family member or blood relative</u> have presently or have had in the past:
   a. Dry Eyes Relation:
   b. Cataract Relation:
   c. Macular Degeneration Relation:
   d. Retinal Detachment Relation:
   e. Glaucoma Relation:
   f. Keratonoconus Relation:
   g. Other (please list condition *and* relation):

_____

_____

_____

4. Please circle any condition(s) <u>you</u> have presently or have had in the past:
   a. High Blood Pressure
   b. Heart Problem
   c. Arthritis: Rheumatoid Arthritis Osteoarthritis
   d. Lung Problems
   e. Stroke
   f. Thyroid Problems
   g. Diabetes Type I Type II
      i. What is your most recent blood sugar level (mg/dl)? _____
      ii. Date and time of day blood sugar level was obtained: _____at_____
      iii. What is you HbA1c? _____
   h. High Cholesterol
   i. Ulcers
   j. Cancer
   k. Other:_____

_____

_____

_____

_____

_____

5. Please circle any condition(s) your family/blood relative have presently or have had in the past and please list the relation:
   a. High Blood Pressure — Relation:
   b. Heart Problem — Relation:
   c. Arthritis: Rheumatoid Arthritis Osteoarthritis — Relation:
   d. Lung Problems — Relation:
   e. Stroke — Relation:
   f. Thyroid Problems — Relation:
   g. Diabetes Type I Type II — Relation:
   h. High Cholesterol — Relation:
   i. Ulcers — Relation:
   j. Cancer — Relation:

6. Other (please list condition and relation):

_____

_____

_____

_____

7. If you are between ages 50-75: Did you get your annual colorectal cancer screening/colonoscopy (please circle)? Yes No
8. Have you received the annual flu shot (please circle)? Yes No
9. Have you ever received pneumococcal/pneumonia vaccine (please circle)? Yes No
10. If you are a female between ages 45-74: Are you receiving an annual mammogram? Yes No
11. Were you a former smoker or do you currently smoke? Yes No
    a. If yes, please circle your smoking status:
       i. Current every day smoker
       ii. Current some day smoker
       iii. Former smoker
       iv. Smoker, current status unknown
       v. Light tobacco smoker
       vi. Heavy tobacco smoker

12. Please list any ocular medications or drops that you are currently using, which eye you use the ocular medications for, along with the frequency with which you use the medications/drops:

Ocular Medication Name	Eye (Both, Right, Left)	Frequency of usage

13. Please list any other medications you are currently using:

1.	11.
2.	12
3.	13.
4.	14.
5.	15.
6.	16.
7.	17.
8.	18.
9.	19.
10.	20.

14. Have you ever used Flomax (please circle)? Yes No

15. Please list any eye surgeries/procedures that have been performed on you, which eye(s), the physician who performed the surgery/procedure, and the date of the surgery/procedure:

Ocular Surgery/Procedure	Eye(s): Both, Right, Left	Physician	Date

16. Please list any allergies you have:

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE AND CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

PLEASE read before signing the Acknowledgement and Consent

This acknowledgement of Notice and Consent authorizes Eye Physicians of Lancaster, PC to use and disclose health information about you for treatment, payment and health care operations purposes.

Notice of Privacy Practices	Eye Physicians of Lancaster has a Notice of Privacy Practices which describes how we may use and disclose your Protected Health Information ("PHI") and how you can access your Protected Health Information and exercise other rights concerning your Protected Health Information.
Amendments	We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all Protected Health Information that we maintain, including information created or obtained prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request to our Privacy Officer.

HOW to contact our Privacy Officer:

Eye Physicians of Lancaster
810 Plaza Boulevard, Suite 103
Lancaster, PA 17601-2738

ATTN: Office Manager
Telephone: 717-735-6700
Facsimile: 717-735-8113

Acknowledgment and Consent (Please PRINT all information except your signature.)

I have received the Notice of Privacy Practices for Eye Physicians of Lancaster, PC. Eye Physicians of Lancaster, PC is authorized to use and disclose health information regarding (patient name) _____ for treatment payment and healthcare operations purposes consistent with its Notice of Privacy Practices.

_____ _____
Signature of Patient (or personal representative**) Date

**Personal representative information (if applicable). Please note: If patient is represented by a person with Power of Attorney, we require a copy of the Power of Attorney on file.

_____ _____
Printed name of Personal Representative Relationship

The following individual(s) may be contacted to discuss my medical care if necessary:

NAME:_____ RELATIONSHIP:_____

ADDRESS:_____ _____

PHONE:_____ FAX:_____

NAME:_____ RELATIONSHIP:_____

ADDRESS:_____ _____

PHONE:_____ FAX:_____

NAME:_____ RELATIONSHIP:_____

ADDRESS:_____ _____

PHONE:_____ FAX:_____

PRINTED PATIENT NAME: _____

PATIENT SIGNATURE:_____

WITNESS:_____ DATE:_____

This remains effective until further written notice is received by the patient.

Self-Pay: You will be considered self-pay if you have no insurance coverage, if you are unsure if you have insurance coverage, or do not provide your insurance information at the time of your visit. Payment in full is required at the time of service. We will provide you with a detailed receipt of all services performed that you may submit to an insurance company.

Non-Covered Services: EPL participates with most insurance plans. Although you may have insurance it is not a guarantee that all services will be paid for by your insurance company. Non covered services are your financial responsibility.

Medical Records: Patients transferring their care to another physician may have their records requested by the new physician and faxed to the new provider at no charge. Patients who want personal copies of their records will be charges a $35 record management fee. A Request may take up to 5 business days to process.

I have read the above policy regarding my financial responsibility to Eye Physicians of Lancaster for providing services. I certify that the information provided is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Eye Physicians of Lancaster. I agree to pay Eye Physicians of Lancaster the full and entire amount of all bills incurred and any amount due after payment has been made by my insurance carrier.

Patient or Guardian Signature _____Printed Name_____Date _____

CONSENT OF TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Eye Physicians of Lancaster through its appropriate personnel, to furnish medical care and treatment to me or the above-named patient, considered necessary and proper in diagnosing my/their physical condition

Patient or Guardian Signature _____Printed Name_____Date _____

EYE PHYSICIANS OF LANCASTER
THOMAS F. KRULEWSKI, M.D. PH.D.
Diplomate, American Board of Ophthalmology

Statement of Financial Responsibility

Name _____

The service you have elected to participate in implies a financial responsibility on your part. This responsibility obligates you to ensure payment in full of your fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. **However, you are ultimately responsible for the payment of your bill at the time services are rendered.**

You are responsible for payment of any copayment, deductible, coinsurance, or out of pocket expense at the time services are rendered. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amount not covered by your insurer. If your insurance carrier denies any part of your claim, or if other services/testing are provided which are not covered or are under deductible guidelines, you will be responsible for your account balance in full at the time of service. **It is the patient's responsibility to know the terms of their insurance plan.**

Outstanding Balance Policy: It is our office policy that all past due accounts be sent three statements. If payment is not made on the account is not made within one month of the final statement, the account will be sent to a collection agency. In the event an account is turned over for collections, the person financially responsible for the account will be responsible for all collections costs including attorney fees and court costs plus an additional $40 collection fee. Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of the service. Our office will not bill any other personal party.

Minors: The parent(s) or guardian(s) is responsible for full payment and will receive the billing statements. A signed release to treat may be required for unaccompanied minors.

Returned Checks: The charge for a returned check is $35 payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash only basis following any returned check.

Referrals: If your insurance plan requires a referral from your primary care physician, it is your responsibility to obtain the referral prior to your appointment. If you do not have a referral at the time of your appointment your appointment may be rescheduled.