EDWARD M STROH MD PC RETINA New Patient Packet

PATIENT INFORMATION

First Name		Middle		Last
Birth Date / /		Age	Gender: MALE FEMALE	
Street Address		City	State	Zip
Home Phone ( )	Cell Phone ( )	Other Phone ( )	Social Security # - -	
Employer		Work Phone ( )		
Next of Kin/Emergency Contact Name		Relationship	Phone # ( )	
Patient Marital Status (please circle): Single - Married - Divorced - Widowed - Legally Separated - Other				
Race:	Email addresses:			
Occupation	Street Address	City	State	Zip

INDIVIDUAL RESPONSIBLE FOR PAYMENT

First Name		Middle	Last
Street Address	City	State	Zip
Home Phone ( )	Work Phone ( )	Employer	Social Security # - -

PRIMARY INSURANCE COMPANY

Company	Policy ID #	Group # HMO	
Name of Policy Holder	DOB	SSN	Relationship to Insured

SECONDARY INSURANCE COMPANY

Company	Policy ID #	Group # HMO

PHARMACY INFORMATION

1____

Name Address City State Phone

2____

Name If using Mail Order Phone Fax

IS YOUR VISIT NO FAULT OR WORKER'S COMPENSATION RELATED? **Yes___ No___**

Are you currently staying in a skilled nursing facility? **Yes___ No___**

____

Name of Skilled or Nursing Facility Address City State Phone

Name: ____ DOB: ___/___/_____ Date: ___/___/_____

Reason For Your Visit and History of Present Eye Complaint

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____

____

Current Eye Medications: (Please list all) ____

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Drug Allergy:	Reaction	Severity
______________	______________	mild / moderate / severe
______________	______________	mild / moderate / severe
______________	______________	mild / moderate / severe

Past Ocular History: (Please mark all that apply)

☐ Overall Healthy	☐ Cataracts	☐ Glaucoma	☐ Dry Eyes
☐ Diabetic Retinopathy	☐ Astigmatism	☐ Myopia (Near Sightedness)	☐ Corneal Ulcer
☐ Macular Degeneration	☐ Aphakia	☐ Hyperopia (Far Sightedness)	☐ Keratoconus
☐ Retinal Detachment	☐ Amblyopia (Lazy Eye)	☐ Optic Neuritis	☐ Optic Neuropathy

Other:

Ocular Surgeries: (Please mark all that apply, which eye and Dates)

☐ No prior ocular surgery	☐ Foreign Body Removal	☐ Punctal Plugs	☐ Trabeculectomy (Glaucoma surgery)
☐ Retinal Laser Surgery	☐ Vitrectomy	☐ RK/LASIK	
☐ Cataract Surgery	☐ Strabismus Surgery	☐ Corneal Transplant	☐ Blepharoplasty

Dates and Details

Ocular Significant Illnesses: (Please mark all that apply)

☐ Overall Healthy	☐ Herpes	☐ Hypothyroidism	☐ Sjogrens or Dry Eyes
☐ AIDS	☐ HIV Positive	☐ Lupus	☐ Graves Disease
☐ Diabetes	☐ Hypertension	☐ Multiple Sclerosis	☐ Hyperthyroidism
☐ Rheumatoid Arthritis	Other______________________		

LIST OF ALL HEALTHCARE PROFESSIONALS YOU SEE (please write any additional ones on the back)

Name	Specialty	Town	Phone
______	______	______	______
______	______	______	______
______	______	______	______
______	______	______	______
______	______	______	______
______	______	______	______

Name: ____ DOB: ___/___/_____ Date: ___/___/_____

PLEASE LIST ALL MAJOR ILLNESSES YOU HAVE HAD IN THE PAST AND ALL PREVIOUS SURGERIES AND HOSPITALIZATIONS: (including dates)

____

____

____

____

____

____

Please mark all that apply:

☐ No history of illnesses	☐ Congestive Heart Failure	☐ Hepatitis	☐ Lung Disease
☐ Anemia	☐ COPD	☐ High Blood Pressure	☐ Lupus
☐ Arthritis	☐ Diabetes	☐ High Cholesterol	☐ Migraine
☐ Arrhythmia	☐ Eczema	☐ HIV	☐ Polymyalgia
☐ Asthma	☐ Fibromyalgia	☐ Kidney Disease	☐ Psychiatric Disorder
☐ Bleeding Disorder	☐ Headache	☐ Kidney Stones	☐ Skin Cancer
☐ Cancer Dates and Type(s): ____________________		☐ Hearing Loss	☐ Liver Disease
☐ Stroke Dates: ____________________________		☐ Thyroid Disease	

Current Other Medications: (Please list) ____

____

____

Infections: **(Please mark all that apply)**

☐ Overall Healthy	☐ Herpes Simplex	☐ HIV / AIDS	☐ Syphilis
☐ Chicken Pox	☐ Herpes Zoster / Shingles	☐ Meningitis	☐ Toxoplasmosis
☐ Hepatitis A / B / C	☐ Histoplasmosis	☐ MRSA	☐ Wound Infection

Other:

Family History:

☐ Arthritis	☐ Diabetes	☐ Kidney Disease	☐ Stroke
☐ Blindness	☐ Glaucoma	☐ Lazy Eye	☐ TB

☐ Cancer Type(s): ____

☐ Heart Disease	☐ High Blood Pressure	☐ Kidney Disease	☐ Sickle Cell Disease
☐ Macular Degeneration Wet	☐ Macular Degeneration Dry	☐ Retinal Detachment	
☐ Cataracts	☐ Retinal Disease	☐ Retinal Vein Occlusion	

Other:

Social History: **(Please mark all that apply)**

Smoking: ☐ current every day smoker ☐ current some day smoker ☐ former smoker ☐ never smoked

Alcohol Use: ☐ Yes ☐ No If yes how much and how often ______________________________

Drug Use: ☐ Yes ☐ No If yes what and how often __________________________________

Name: ____ DOB: ___/___/_____ Date: ___/___/_____

Review of Systems: (Please mark all that apply)

Eyes
- □ Previous Surgery
- □ Contact Lens
- □ Pain
- □ Double Vision
- □ Glaucoma
- □ Cataracts
- □ Macular Degeneration
- □ Dry Eyes
- □ Flashes
- □ Floaters
- □ Gastrointestinal

Skin
- □ Rash / Sores
- □ Lesions
- □ Hives / Eczema
- □ Rosacea

Cardiovascular
- □ Chest Pain
- □ Dizziness
- □ Fainting Spells
- □ Shortness of Breath
- □ Irregular Heart Beat
- □ Difficulty Lying Flat

Endocrine
- □ Increased Thirst
- □ Increased Hunger
- □ Increased Urination
- □ Increased Sweating
- □ Fingernail Changes

Respiratory
- □ Cough
- □ Congestion
- □ Wheezing
- □ Asthma
- □ Pneumonia

Gastrointestinal
- □ Heartburn
- □ Ulcer
- □ Nausea / Vomiting
- □ Jaundice / Hepatitis
- □ Gastrointestinal

Ear, Nose, and Throat
- □ Hard of Hearing
- □ Ringing in Ears
- □ Vertigo
- □ Infection

Psychiatric
- □ Anxiety / Depression
- □ Mood Swings
- □ Difficulty Sleeping
- □ Numbness
- □ Other

Immunologic
- □ Hives
- □ Itching
- □ Runny Nose
- □ Sinus Pressure

Blood / Lymph Nodes
- □ Easy Bruising
- □ Gums Bleed Easy
- □ Prolonged Bleeding
- □ Heavy Aspirin Use
- □ Other _________________

Musculoskeletal
- □ Stiffness
- □ Arthritis
- □ Joint Pain / Swelling
- □ Amputation
- □ Infections

Genitourinary
- □ Pain / Difficulty
- □ Blood in Urine
- □ History of Kidney Stones
- □ History of STD's

Neurological
- □ Seizures
- □ Weakness/Paralysis/Stroke
- □ Numbness
- □ Alzheimer's
- □ Parkinson's
- □ Pseudotumor Cerebri
- □ Tremors

Constitutional
- □ Fatigue / Weakness
- □ Fever
- □ Weight Gain / Loss

I have completed this medical history to the best of my ability: Initial:__________ Date:_____________

Consent for Examination including Dilating Eye Drops:

I hereby consent to such examination procedures as in the judgment of my physicians may be considered necessary or advisable as long as I am a patient of DR STROH / EMSMDPC / RCLI. I accept that my treatment and care may be observed and/or aided by physicians and/or other assistants under supervision.

I hereby authorize physicians and/or their assistants to administer dilating eye drops to me as long as I am a patient of DR STROH / EMSMDPC / RCLI. Dilating drops are used to dilate or enlarge the pupils of the eye to allow the physician to get a better view of the inside of your eye. Dilating drops may blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your physician to predict how much your vision will be affected. **Because walking or driving may be difficult immediately after your examination, you should be prepared to have an assistant or driver in case you feel you are unable to walk or drive safely.** Adverse reactions, such as acute angle-closure glaucoma, may be triggered by dilating drops. This is rare and treatable with immediate medical attention.

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PATIENT'S NAME (Please Print) PATIENT'S SIGNATURE DATE

EDWARD STROH M.D. 165 N. Village Ave, Suite 203 * Rockville Centre, NY 11570 * TEL 516-536-9525 FAX 516-536-9530

OUR FINANCIAL POLICIES

Your clear understanding of our Financial Policies is important to our relationship. Please ask if you have any questions about our fees, financial policy or your responsibility.

• **PARTICIPATION:** We do participate with many insurance plans; please confirm that our office accepts your insurance and/or Specific Plan as you may be responsible for any out of network fees, co-pays, or deductibles..

• REMITTANCE: If your insurance plan pays you directly, you agree to forward payment immediately.

• COPAYS:

• Payment for our services are due at time of visit; if your insurance plan requires copayment both the patient and physician are legally required to abide by this requirement.

• You will incur a **$15** service charge for copayments not paid at the time of service.

• If a check is returned for insufficient funds or stop payment, you will incur a **$35** surcharge fee

• A credit card processing fee or paperwork fee applies to all credit card transactions.

MISSED APPOINTMENT FEE

• A fee of **$20** will be incurred for all no show appointments without calling our office at least 1 hour in advance.

COINSURANCE/DEDUCTIBLES:

• Payment is expected promptly once your insurance plan informs our office that these expenses are patient responsibility, either in advance or after your visit.

• You will receive a statement from our billing offices that will outline your insurance company's payments as well as patient responsibility.

• **It is your responsibility to notify our office of any change in Primary, Secondary, or Tertiary insurance in advance or at the time of your visit.** Failure to do so may result in denied claims and you would be responsible.

You will receive a statement from our billing offices that will outline your insurance company's payments as well as patient responsibility.

MEDICARE PATIENTS:

• You are responsible for your yearly deductible and the 20% portion not paid by Medicare if you do not have secondary insurance

• If you have supplemental coverage, as a courtesy we will submit the claims for you.

• If you are enrolled in a Medicare HMO plan (such as Oxford, Aetna, United Healthcare, HIP, etc.), or if your Medicare HMO plan has changed, it is your responsibility to inform our staff before your visit.

• If the appropriate referrals are not obtained, you will be responsible for full payment of fees.

SELF PAY PATIENTS:

• Payment in full is expected at time of service.

NO FAULT/WORKERS COMPENSATION PATIENTS

• If the reason for your visit is due to a work related injury or because of an auto accident, you must inform the front desk so that you can discuss your situation with our billing staff. Failure to do so and providing us with all necessary information could lead to denied claims and you would be financially responsible.

AFFORDABLE CARE PLANS/HEALTHCARE EXCHANGES

• You are responsible for paying your Healthcare premiums in a timely manner. Failure to pay your insurance premiums will result in your benefits being terminated. If your insurance is cancelled for failure to pay your premium, or any other reason, you will be held liable for the amount of the bill. This amount will be due in full upon notice.

REFERRALS AND AUTHORIZATIONS: REFERRALS AND AUTHORIZATIONS:

• If your plan requires authorization from a primary care physician, it is your responsibility to obtain the written referral or authorization number prior to your visit with the doctor.

• YOUR APPOINTMENT WILL BE RESCHEDULED IF PROPER AUTHORIZATION HAS NOT BEEN OBTAINED

Surgery/Drug Treatment Policy

You agree to be responsible for any out of pocket expenses (ex. copayment, deductible, coinsurance) required by your insurance plan

• IMPORTANT: Any changes in your insurance company, plan, or deductibles must be stated at the time of visit, and you must bring any new insurance cards to the office and present them to our staff upon arrival. Failure to do so would leave you responsible for unpaid charges.

•If I have switched or Have a managed care plan that requires a referral, I understand that I am responsible to have a valid referral with me when I arrive for my appointment(s) without exceptions.

By signing below, you are acknowledging that you have read and fully understand our Financial PolicyPatient/

PATIENT/Responsible Party Signature:____Date:_____________

CONFIDENTIALITY:

In an effort to provide the most efficient and effective healthcare, your treating physician will diagnose your illness according to your complaints, symptoms, test results, and medical history. In order to treat the patient appropriately, the patient understands and authorizes treating physician and/or facility to obtain any and all medical records relating to the patient and to communicate with previous physicians by any method, and/or any physician that can assist with the care of the patient, as long as confidentiality is kept at the physician level. I have read, understand, and agree with the above. I permit you to release any medical information to the physicians involved in my care. I consent to the practice of calling my home or other designated location and leaving a message on voice mail or in person in reference to an appointment reminder or any insurance item or bill. In addition, the practice may mail to my home appointment reminders or patients statements.

Patient/Guardian Initials: _______________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

As provisioned by the Health Insurance Portability and Accountability Act of 1996 we must provide you with a detailed notice in writing of our privacy practices. By signing this notice you have acknowledged receipt of our Notice of Privacy Practices. I have been offered to read/receive a copy of **Edward M. Stroh MD PC/Retina Consultants of Long Island** Notice of Privacy Practice.

Patient/Guardian Initials: _______________

I authorize **Edward M. Stroh MD PC/Retina Consultants of Long Island** to release medical information for insurance purposes. I authorize payment to be made directly to **Edward M. Stroh MD PC/Retina Consultants of Long Island** if my insurance company indicates an assignment. As a courtesy, **Edward M. Stroh MD PC/Retina Consultants of Long Island** will contact insurance companies for authorization for services required. **Edward M. Stroh MD PC/Retina Consultants of Long Island** is not responsible for lapses of insurance or for incorrect information.

I have read, understand, and agree with office financial agreement.

Patient/Guardian Initials: ______________

FAILURE TO FOLLOW PHYSICIAN ORDERS:

"Physician Orders" are meant to improve and/or resolve the patient's medical condition and/or symptoms. The patient is expected to follow orders given. In the event the patient does not follow orders given, the patient may be discharged from the treating physician care and/or facility, thus releasing treating physician and/or facility from any injury or illness claim resulting from the patient's failure to follow orders. Not following orders given can included but is not limited to missing, postponing or refusal of additional tests to rule out, confirm or discover illness or failure to attend follow-up appointments. I have read, understand, and agree with the above.

Patient/Guardian Initials: ______________

CONSENT TO RELEASE INFORMATION: (PLEASE CIRLE YES OR NO)

1. I permit the practice to release any medical information to the physicians involved in my care **YES NO**
2. I permit the practice calling my home or other designated location and leaving a message on voice mail or in person in reference to my care and treatment, appointment reminders, insurance items, statements, and medical records. **YES NO**
3. I permit the practice to mail to my home appointment reminders, patient statements, and medical records. **YES NO**
4. I permit the practice to email to my home information regarding medical care, even though I have been informed the email is unencrypted format and there is a risk of breach of confidentiality. **YES NO**

SIGNATURE: ____Date:_____________

I designate the following representative(s) who the provider can communicate with on my behalf (example, spouse, son, daughter, friend, etc) If you do not designate anyone, the doctor will be unable to speak to anyone in your family regarding your medical condition.)

Name: ____Relationship___________________Tel: __________________

Name: ____ Relationship___________________ Tel: __________________

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY FOR USE OF NON-PARTICIPATING PROVIDERS

I hereby acknowledge & understand that under the terms of my insurance plan should I at any time and for whatever reason utilize the non-emergent services of any non-participating provider (including, but not limited to, doctor, laboratory, radiology and/or other ancillary services) I may not be covered in whole or in part of the associated costs and will bear the full financial responsibility for the costs of such services.

I Understand the above and certify that my visits are not related to a third party claim (such as legal action, dispute resolution, or assigning of fault regarding injuries or disease

PATIENT/Responsible Party Signature:____Date:_____________

Name: ____ DOB: ___/___/_____ Date: ___/___/_____

Current Prescription and Over The Counter Medication List

____

Pharmacy Name Address City State Phone

DRUG NAME	DOSAGE	HOW OFTEN	PILL DROPS INJ	I Started	I Stopped	Why I take	Who Prescribed

For Office Use Only

Updated by:	Date:	Updated by:	Date:	Updated by:	Date:	Updated by:	Date:	Updated by:	Date:

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