Conshohocken Eye & Laser Center

PATIENT INFORMATION

Patient's Name: _____ Referred By: _____

Sex: _____ Birthdate: _____ Address: _____

Address: _____ Telephone: _____

_____ Primary Care Physician: _____

Home Phone: _____ Work/Cell: _____ Address: _____

SSN (only for workers' comp): _____ Telephone: _____

How did you hear about our practice?_____

Emergency Contact: _____

AUTHORIZATION FOR BENEFIT ASSIGNMENT AND INFORMATION RELEASE

I hereby assign any benefits payable to Conshohocken Eye & Laser Center, P.C. for providing medical services. I understand that I am responsible for any balance in excess of the benefits/contract payable by this plan. I understand that insurances will only pay for services that they determine to be “reasonable and necessary” according to their respective standards and policies. If my insurance determines that a particular service is not “reasonable and necessary”, I will be responsible for any balance due for medical services performed. I have read the Notice of Fees and Procedures and agree to this policy.

I understand that it is my responsibility to schedule and attend all appointments as recommended by Dr. Fracht, as well as to comply with all written and verbal instructions. If I fail to show for an appointment, cancel, or are overdue, I will receive a reminder via telephone and the Conshohocken Eye & Laser Center staff may leave a message at the designated phone number. I understand that failure to comply with regard to appointments and/or instructions may affect the outcome of my treatment and could result in vision loss and deterioration of my eye condition.

Conshohocken Eye & Laser Center, P.C. may disclose information about me and the treatment that I am receiving, including copies of my medical record for purposes of treatment, payment and operations as described in our Privacy Notice. In addition, I hereby authorize Conshohocken Eye & Laser Center to:

1. Release my medical information to the following: _____

2. Leave messages on work/home voicemail: Yes ☐ No ☐

I acknowledge that I have been offered the Conshohocken Eye & Laser Center Privacy Notice.

Signed: _____ Date: _____

Print Name: _____

MEDICAL HISTORY

1. Have you ever been treated for any medical conditions (e.g., diabetes, high blood pressure, arthritis, etc.)?

Yes ☐ No ☐ If yes, please explain: _____

2. Have you had any eye disease (e.g., glaucoma, cataract, wandering or "lazy" eye, retinal detachment, etc.)

Yes ☐ No ☐ If yes, please explain: _____

3. Have you ever had any surgery?

Yes ☐ No ☐ If yes, please provide date and reason: _____

4. Have you ever been hospitalized?

Yes ☐ No ☐ If yes, please provide date and reason: _____

5. Do you take any medications?

Yes ☐ No ☐ If yes, please list: _____

Do you take any eye medications

Yes ☐ No ☐ If yes, please list: _____

6. Do you have any drug or food allergies?

Yes ☐ No ☐ If yes, please list: _____

REVIEW OF SYSTEMS

Do you currently have any of the following problems:	Yes	No	If yes, please explain:
Chronic fever, unexpected weight loss/gain, fatigue			
Ear/nose/throat problems (e.g. hearing loss, sinus problems, sore throat)			
Heart problems (e.g. chest pains, irregular heartbeat)			
Respiratory problems (e.g. shortness of breath, wheezing, coughing)			
Gastrointestinal problems (e.g. heartburn, abdominal pain, diarrhea)			
Urinary problems (e.g. pain or discomfort, blood in urine)			
Skin problems (e.g. rashes, excessive dryness)			
Musculoskeletal problems (e.g. muscle ache, joint pain, swollen joints)			
Neurologic problems (e.g. numbness, weakness, headaches)			
Psychiatric problems (e.g. depression, anxiety)			

FAMILY AND SOCIAL HISTORY

Do any medical or eye diseases run in your family (e.g. diabetes, high blood pressure, cancer, glaucoma, macular degeneration)?

Yes ☐ No ☐ If yes, please explain: _____

Do you smoke? Yes ☐ No ☐ If yes, how much? _____

Drink alcohol? Yes ☐ No ☐ If yes, how much? _____

If employed, how many hours per week do you work? _____

Comments: _____

MD Signature: _____ Date: _____