

Your insurance requires all information be completed. Please bring this completed form to your appointment.

Mr. Mrs. Miss Ms.	First Name	Middle Initial	Last Name	
Mailing Address/P.O. Box		Home Address (If different)		
City		State	Zip Code	
Alternate Address (winter address if applicable)		State	Zip Code	
Home Phone	Work Phone		Cell Phone	
Date of Birth	Social Security #		E-mail	
Insurance: (Please show your insurance cards at every visit)				
Insurance Carrier (Primary)		Policy #	Group #	
Subscribers Name		Relationship	Subscribers Date of Birth	
Secondary Insurance (if Applicable)		Policy #	Group #	
Employer: (This section must be filled out completely even if self employed)				
Company Name		Occupation	Phone	
Address		City	State	Zip Code
Spouse / Guardian Information:				
Spouse/ Full Name		Date of Birth	Social Security #	Work #
				Cell #
In Case of Emergency, Notify:				
Name		Home Phone #		
Address		Cell #		
Relationship		Work #		
Your Primary Care Physician:		Your Optometrist: (if applicable)		
Name		Name		
Address		Address		
Phone number		Phone number		
Who Referred You to Us?		Your Pharmacy		Drug Plan
Name		Name		Name
		Address		
Relationship		Phone number		

Your Insurance company requires all information be completed.

Current Medications:		Office Changes (date & initial)

Allergies: (list all medications, foods, etc.)	Do You Use Aspirin? Yes___ No___
	Blood Transfusion? Yes___ No___
	Communicable Disease? Yes___ No___
Do You Have a Latex Allergy? Yes___ No___	Social History:
	Occupation _____
	Do You Smoke? Yes___ No___
	Do You Drink Alcohol? Yes___ No___

Past Eye Problems:	<u>Yes</u>	<u>No</u>	Previous Eye Surgery:
Glaucoma.....	___	___	
Macular Degeneration	___	___	
Inflammation.....	___	___	
Trauma.....	___	___	Previous Eye Laser:
Steroid Use.....	___	___	
Lazy Eye.....	___	___	
Other:	___	___	

Current Eye Problems:	<u>Yes</u>	<u>No</u>	Office Changes (date & initial)
Loss of Vision.....	___	___	
Blurred Vision.....	___	___	
Distorted Vision.....	___	___	
Loss of Side Vision...	___	___	
Double Vision.....	___	___	
Dryness.....	___	___	
Mucous Discharge...	___	___	
Redness.....	___	___	
Itching.....	___	___	
Burning.....	___	___	
Tearing.....	___	___	
Light Sensitivity.....	___	___	
Glare.....	___	___	
Chronic Infection.....	___	___	
Eye Pain.....	___	___	
Styes.....	___	___	
Other:	___	___	

CONTINUED ON OTHER SIDE

Current Medical Problems:			Office Changes <i>(date & initial)</i>
	Yes	No	
Cardiovascular, Heart, Stroke,	_____	_____	
High Blood Pressure, Cholesterol	_____	_____	
Endocrine, Diabetes, Thyroid	_____	_____	
Respiratory, Breathing, Lungs,	_____	_____	
Asthma.....	_____	_____	
Ear, Nose, Mouth, Throat.....	_____	_____	
Gastrointestinal, Stomach	_____	_____	
Bones, Joints, Muscles.....	_____	_____	
Neurological Problems.....	_____	_____	
Blood or Lymph Problems....	_____	_____	
Allergic or Immunologic.....	_____	_____	
Psychiatric.....	_____	_____	
Fever, Weight Loss.....	_____	_____	
Sexually Transmitted Disease	_____	_____	
Skin, Rashes, etc.....	_____	_____	
Headaches or Migraines.....	_____	_____	
Cancer _____	_____	_____	
Other: _____	_____	_____	

Past Medical Problems:		Yes	No			Yes	No
High Blood Pressure..	_____	_____	_____	Lung Disease.....	_____	_____	_____
Low Blood Pressure..	_____	_____	_____	COPD.....	_____	_____	_____
Diabetes.....	_____	_____	_____	Hyper/Hypo Thyroid....	_____	_____	_____
Heart Disease.....	_____	_____	_____	HIV Positive.....	_____	_____	_____
Vascular Disease.....	_____	_____	_____	Migraines/Headaches	_____	_____	_____
Previous Stroke.....	_____	_____	_____	Autoimmune Disease	_____	_____	_____
Arrhythmia.....	_____	_____	_____	Hepatitis A B C	_____	_____	_____
Asthma.....	_____	_____	_____				

Other Past Health Problems: *(please list)*

Have You Had Any Surgeries? Yes ___ No ___ *(please list)*

Family History: *(please list relation in blank space)*

Glaucoma.....	_____	Diabetes.....	_____
Cataracts.....	_____	Cancer.....	_____
Macular Degeneration...	_____	Other:	_____
High Blood Pressure	_____		
Heart Disease.....	_____		

Patient Signature: _____	Date: _____
Dr. Signature: _____	Date: _____

Signature on File, Assignment of Benefits, Financial Agreement

1. MEDICARE: I request that payment of authorized Medicare benefits be made on my behalf to Post, O'Connor & Kadrmas Eye Centers for services furnished me by Post, O'Connor & Kadrmas Eye Centers. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Post, O'Connor & Kadrmas Eye Centers accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

2. MEDIGAP: I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Post, O'Connor & Kadrmas Eye Centers, if possible or otherwise to me.

3. RELEASE OF INFORMATION: Post, O'Connor & Kadrmas Eye Centers may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to Post, O'Connor & Kadrmas Eye Centers for reimbursement for services rendered, and (2) any health care provider for continued patient care. Post, O'Connor & Kadrmas Eye Centers may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.

4. OTHER INSURANCE: I understand that Post, O'Connor & Kadrmas Eye Centers maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office and that Post, O'Connor & Kadrmas Eye Centers has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Post, O'Connor & Kadrmas Eye Centers if I belong to a plan that does not appear on the above mentioned list.

5. NON-COVERED SERVICES: I understand that Post, O'Connor & Kadrmas Eye Centers contracts with health care service plans (i.e. HMO's, PPO's) relate only to items and services which are covered by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Post, O'Connor & Kadrmas Eye Centers to obtain necessary health care service plan authorizations.

6. FINANCIAL AGREEMENT: I agree that in return for the services provided to the patient by Post, O'Connor & Kadrmas Eye Centers, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Post, O'Connor & Kadrmas Eye Centers for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to Post, O'Connor & Kadrmas Eye Centers. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Post, O'Connor & Kadrmas Eye Centers. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

Beneficiary Signature or Authorized Party

Date