Kadrmas Eye Care New England 1-508-746-8600

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 Address Phone number	Name Address Phone number

Who Referred You to Us?	Your Pharmacy	Drug Plan
Name Relationship	Name Address Phone number	Name

Your Insurance company requires all information be completed.

Current Medications: (including vitamins/supplements)		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:	Yes	No	Previous Eye Surgery:
Glaucoma…………..	____	____	
Macular Degeneration	____	____	
Inflammation…………	____	____	
Trauma……………….	____	____	Previous Eye Laser:
Steroid Use………..	____	____	
Lazy Eye……………	____	____	
Other:			

Current Eye Problems:	Yes	No	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:	____	____	

Current Medical Problems:	Yes	No	Office Changes *(date & initial)*
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:**

CONTINUED ON OTHER SIDE

Signature on File, Assignment of Benefits, Financial Agreement

1. MEDICARE: I request that payment of authorized Medicare benefits be made on my behalf to Kadrmas Eye Care New England for services furnished me Kadrmas Eye Care New England. 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. Kadrmas Eye Care New England 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.

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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 Kadrmas Eye Care New England, if possible or otherwise to me.

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3. RELEASE OF INFORMATION: Kadrmas Eye Care New England 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 Kadrmas Eye Care New England for reimbursement for services rendered, and (2) any health care provider for continued patient care. Kadrmas Eye Care New England 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.

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4. OTHER INSURANCE: I understand that Kadrmas Eye Care New England 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 Kadrmas Eye Care New England 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 Kadrmas Eye Care New England if I belong to a plan that does not appear on the above mentioned list.

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5. NON-COVERED SERVICES: I understand that Kadrmas Eye Care New England 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 Kadrmas Eye Care New England to obtain necessary health care service plan authorizations.

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6. FINANCIAL AGREEMENT: I agree that in return for the services provided to the patient by Kadrmas Eye Care New England, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Kadrmas Eye Care New England 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 Kadrmas Eye Care New England If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them Kadrmas Eye Care New England. 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