Marion Eye Center **PATIENT INFORMATION** **Delaware Eye Center**

Today's Date: _____ Cell Phone: _____ Home Phone:_____

Patient Name: _____

Last Name First Name Middle

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ SS#: _____ Gender: Male Female

Marital Status: Single Married Widowed Email: _____

Business Name & Address: _____

Business Phone: _____ Occupation: _____

Spouse/Responsible Party/POA ( ) mark here if self

Name: _____ Relationship to patient: _____

Date of Birth: _____ SS#: _____

Primary Insurer: _____ Secondary Insurer: _____

Primary Physician: _____ Optometrist (glasses doctor): _____

Name of Pharmacy: _____ **Location**: _____

Who do we have to thank for your referral to our office: _____

Marion and Delaware Eye Centers are authorized to release information to the following person(s):

Name_____Relationship_____ phone_____

Name_____Relationship_____ phone_____

ASSIGNMENT & RELEASE – General and Secondary Insurances

I, the undersigned, have insurance coverage with: _____,
And assign directly to Marion Eye Center, Inc. and Delaware Eye Center, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all current and future insurance submissions.

_____ _____

Signature of Insured or Guardian Date

ASSIGNMENT & RELEASE – Medicare

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Marion Eye Center and Delaware Eye Center for any services furnished me by their physicians. I authorize any holder of medical information about me to release to the CMS (Centers for Medicare & 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 on item 9 of the HCFA-1500 Performa, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. For Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Signature of Insured or Guardian Date

SECTION A – General Information

MEDICATIONS: ____See list below ____See Photocopy ____Contact Primary ____Unsure of Meds

Medication Name	Dosage	Frequency

List any medication allergies:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

MEDICAL HISTORY: Do you currently smoke? Yes No Are you a former smoker? Yes No

Have you been diagnosed with? (circle all that apply): Diabetes High Blood Pressure Thyroid Disease

Asthma Stroke Hepatitis Tuberculosis HIV/AIDS COPD/Emphysema Cancer

Seizure Disorder/Epilepsy Heart Disease Other:_____

FAMILY HISTORY: (circle all that apply)

Glaucoma Diabetes Macular Degeneration Other eye problem: _____

SECTION B – If you are a New Patient or have New Problems to report

1. Which of the following problems have you noticed or been told you have by another doctor? (circle all that apply)

Blurred reading vision	Eyelid problem	Cataract – Glare – Halos
Blurred distance vision	Eye redness	Glaucoma
Double vision	Itching/Allergies	Diabetes
Distorted vision	Floaters/Flashes	Other: _____
Tearing	Crossed eyes	_____
Dryness	Need new glasses	

2. Previous eye problems you know of:

Lazy eye (amblyopia) Right eye Left eye

Eye surgery or injury: _____

Other eye disease: _____