Hudson Ophthalmology, Glaucoma and Cataract Surgery, Comprehensive Ophthalmology 1983 Crompond Road Cortlandt Manor, NY 10567

Demographic Questionnaire

Referring Provider: _____

Name: _____ Date of Birth: _____ Sex: M F

Insurance Plan: _____ Ins ID No.: _____ Group No.: _____

Other Insurance Plan: _____ Other Ins ID No.: _____ Other Group No: _____

Insured's Name (if other than self): _____ Date of Birth: _____

Address: _____ Apt: _____ Phone: _____

City: _____ State: _____ Zip: _____ Alternate Phone: _____

Social Security No.: _____ Occupation: _____

Parent/Guardian's Name (if minor): _____

Medical History Questionnaire

Reason for Visit: _____

List all medications you currently take: _____

List all major illnesses (glaucoma, diabetes, high blood pressure, etc.) or injuries: _____

List past surgeries (cataract, appendix, etc.): _____

Do you have any allergies to medications? NO YES (list): _____

Do you currently have any problems in the following areas?	YES	NO	Details
Eyes *(poor vision, eye pain, tearing, halos, dryness, redness, floaters, etc.)*			
General/Constitutional *(fever, weight loss, tired, etc.)*			
Ears, Nose, Throat *(stuffy nose, ear ache, cough, dry mouth, etc.)*			
Cardiovascular *(high blood pressure, racing pulse, etc.)*			
Respiratory *(congestion, wheezing, shortof breath, etc.)*			
Gastrointestinal *(stomach upset, diarrhea, constipation, ulcers, etc.)*			
Genital, Kidney/bladder *(painful/frequent urination, impotence, etc.)*			
Females: Are You Pregnant? Nursing?			
Muscles, Bones, Joints *(join pain, stiffness, swelling, gout, etc)*			
Skin *(warts, growths, rash etc.)*			
Neurological *(numbness, headache, seizures, dizziness, etc.)*			
Psychiatric *(anxiety, depression, insomnia, etc.)*			
Endocrine *(diabetes, hypothyroid, etc.)*			
Blood/Lymph *(bleeding, bruising, anemia, high cholesterol, etc.)*			

Family History/Social History

Has any member of your family (parents, siblings, grandparents) had the following (circle all that apply, or circle: NONE) BLINDNESS, CATARACT, GLAUCOMA, MACULAR DEGENERATION, DIABETES, HYPERTENSION, HEART DISEASE, STROKE, ARTHRITIS, CANCER

Do you drink alcohol? NO YES how much? _____ Have you had a blood transfusion? YES NO

Do you smoke? NO YES how much? _____ For how many years? _____ Do you drive? YES NO

Patient Signature: _____ *Date:* _____

ACKNOWLEGEMENT

I hereby acknowledge receipt of the Notice of Privacy Practices (HIPPA Rules).

Signature: _____ Date: _____

I have read and understand the office Policy.

Signature: _____ Date: _____

I request the payment of authorized Medicare Benefits/ Health Insurance be made either to me or on my behalf to Kerline Marcelin MD, P.C/ Hudson Ophthalmology for services furnished by a physician of the group. I authorize any holder of medical information about me to release to Medicare/ Health Insurance and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature: _____ Date: _____

I understand that I am responsible for all charges for services rendered to me, including the non-covered services, deductibles and balances remaining after payments or non-payment of possible insurance benefits according to my insurance contract.

I agree to pay outstanding balance in full (unless other arrangements are previously made with the office secondary to financial hardship) and *at the time of service.* If submitted to my insurance company, I agree to pay unpaid balance (based on my insurance contract) if not received within 45 days of the date of service.

I agree to pay the fees of any collection agency, which will be based on 30% of the debt, and all costs, and expenses, including reasonable attorneys' fees, we incur in such collections efforts.

Signature: _____ Date: _____

Can we leave a message about your results or medical information?
Yes____ No____

We may speak with:

1. Name_____ 2. No one_____

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