GREATER MARYLAND EYE PHYSICIANS & SURGEONS

Medical History Questionnaire

Name: _____ Date: _____

Date of last eye examination: _____

List all current medications (prescription and over the counter):

1. _____ 7. _____
2. _____ 8. _____
3. _____ 9. _____
4. _____ 10. _____
5. _____ 11. _____
6. _____ 12. _____

Do you have any allergies to any medications? ☐ Yes ☐ No If yes, Please list:

Medication		Symptoms
1. _____	-	_____
2. _____	-	_____
3. _____	-	_____
4. _____	-	_____

Illness Past and Present	Yes	No	Duration	Family History	Yes	No	Relationship
Glaucoma				Glaucoma			
Arthritis				Arthritis			
Cancer				Cancer			
Diabetes				Diabetes			
Heart Disease				Heart Disease			
High Blood Pressure				High Blood Pressure			
Kidney Disease				Kidney Disease			
Stroke				Stroke			
Thyroid Disease				Thyroid Disease			
Asthma/Emphysema				Asthma/Emphysema			
AIDS/HIV				AIDS/HIV			
Hay Fever or Sinus				Hay Fever or Sinus			
Others:				Others:			

List any ***eye surgeries*** you have had (cataract, corneal transplant, etc.):

_____

_____

List any ***surgeries*** you had had (appendectomy, tonsillectomy, etc.):

_____

_____

Occupation: _____

Marital Status: ☐ married ☐ divorced ☐ single ☐ widowed

Do you drive? ☐ Yes ☐ No

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, what year? _____

Do you smoke? ☐ Yes ☐ No If yes, how many packs/day? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks/week? _____

Do you currently have any of the following areas? If yes, please provide information.

REVIEW OF SYSTEMS (Examples)	YES	NO	EXPLANATION OF PROBLEM
EYES (glaucoma, cataracts, blurred vision)			
ALLERGIC/IMMUNOLOGIC (hay fever, lupus, HIV)			
CARDIOVASCULAR (chest pain, palpitations)			
GENERAL/CONSTITUTIONAL (fever, weight loss, fatigue)			
ENDOCRINE (diabetes, hypothyroid)			
GASTROINTESTINAL (nausea, vomiting, heartburn, loss of appetite)			
GENITOURINARY (frequent urination, kidney stones, blood in urine)			
HEMATOLOGIC/ONCOLOGY (anemia, bleeding, bruising tendencies)			
HENT/EARS, NOSE, THROAT (earaches, nose bleeds, sinus disease, sore throat)			
INTEGUMENTARY/SKIN (rash, acne, skin cancer, warts)			
MUSCULOSKELETAL (joint pain, muscle weakness)			
NEUROLOGICAL (headaches, paralysis, seizures)			
PSYCHIATRIC (depression, anxiety, memory loss)			
RESPIRATORY (cough, shortness of breath, wheezing)			

OVER →

PATIENT INFORMATION

Last name:	**First Name:**	**Middle Name:**	☐ **Mr.** ☐ **Mrs.**	☐ **Ms.** ☐ **Dr.**	**Marital Status** ☐ ☐ ☐ ☐ ☐ Single / Mar / Div / Sep / Wid

Race:	**Ethnicity:**	**Preferred Language:**

Is this your legal name? ☐ Yes ☐ No	**If not, what is your legal name?**	**Email Address:**	**Birth date:**	**Age:**	**Sex:**

Mailing Address:

City: **State:** **Zip Code:**

By providing your number, you consent to auto dialer, pre-recorded messages, and messages.

Home Phone #:	**Cell Phone #:**	**Work Phone #:**

How did you hear about our office?	**Is This A Work Related Injury?**

Employer Name: **Occupation:**

Primary Care Physician:	**Referring Provider:**

INSURANCE INFORMATION

Primary Insurance Carrier:

Subscriber Name:

Date of Birth: **Social Security:**

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other	

Name of Secondary Insurance Carrier:	**Subscriber's name:**	**Date of Birth:**	**Social Security:**

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other	

IN CASE OF EMERGENCY

Name of local friend or relative:	**Relationship to patient:**	**Home Phone #:**	**Work Phone #:**

The above information is true to the best of my knowledge. I authorize GMEPS to render treatment to me or my dependent. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize GMEPS or my insurance company to release any information required to process my claims. If an email is provided, you may be contacted for any collection related issues through email. Responsible party of patient will be responsible for all collection or court costs associated with delinquent accounts. Responsible party is also responsible for service charges resulted from delinquent accounts. There will be a $35 fee for all returned checks.

X_____ X_____

Patient/Guardian Signature ***Date***

GREATER MARYLAND EYE PHYSICIANS & SURGEONS

Explanation of Refraction Test Fee

The refraction test fee is the part of your eye exam by which we determine if your vision can be improved. It is also how we determine the best possible visual acuity and function of your eye, which is essential medical information for us to have as we assess your eyes and look for problems. It is **NOT** a covered service by Medicare and many other insurance plans. These plans consider a refraction as a "vision" service and not a "medical" service.

Contact lens exams are also a non-covered service and vary in cost depending on the type of fitting.

Our refraction test fee is **$50.00** and unless your plan automatically covers the refraction charge, this fee is collected at the time of service in addition to any co-payment that your insurance may require. Should your plan pay us for the refraction, we will reimburse you accordingly.

By signing I acknowledge that I have reviewed and understand the Explanation of Refraction Test Fee. If I want the refraction test, I agree to pay any fees related to this non-covered service.

X_____ X_____

Patient/Guardian Signature ***Date***

X_____

Patient/Guardian (Print Name)

OVER ➡

GREATER MARYLAND EYE PHYSICIANS & SURGEONS

GMEPS Cancellation Policy/ No Show Policy for Doctor Appointments

Our goal is to provide quality medical care in a timely manner. In order to do so we had to implement an appointment/cancellation policy. The policy enables us to better utilize available appointments for our patients in need of Ophthalmic care.

1) Cancellation/No Show Policy for Doctor Appointment

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

A "No-Show" is someone who misses an appointment without canceling it withing a 24-hour working day in advance. No-shows inconvenience those individuals who need access to Ophthalmic care in a timely manner.

2) Scheduled Appointments (Being Late)

We understand that delays can happen, however, we must try to keep the other patients and doctors on time. If running late, please notify the office @ 301-868-6700.

If a patient is 30 minutes past their scheduled time, we may have to reschedule your appointment.

The following charges for services in the office:

Same Day Appointment Cancellation- $35.00 No Show Fee - $50.00

Print Patient Name: _____

Patient Signature: _____ Date: _____

PATIENT ACCOUNT NUMBER _____ (OFFICE USE ONLY)

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NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Understanding your health record

A record is made each time you visit a hospital, physician, or other health care provider. Your symptoms, examination, test results, diagnoses, treatment and a plan for future care are recorded. This information is most often referred to as your "health or medical record," and serves as a basis for planning your care and treatment. It also serves as a means of communication among any and all other health professionals who may contribute to your care. Understanding what information is retained in your record and how that information may be used will help you to ensure its accuracy and enable you to relate to who, what, when, where, and why others may be allowed access to your health information. This effort is being made to assist you in making informed decisions before authorizing the disclosure of your medical information to others.

Understanding your health information rights

Your health record is the physical property of the health care practitioner or facility that compiled it but the content is about you and therefore belongs to you. You have the right to request restrictions on certain uses and disclosures of your information, and to request amendments be made to your health record. Your rights include being able to review or obtain a paper copy of your health information, and to be given an account of all disclosures. You may also request communications of your health information be made by alternative means or to alternative locations. Other than activity that has already occurred, you may revoke any further authorizations to use or disclose your health information.

Our responsibilities

This office is required to maintain the privacy of your health information and to provide you with notice of our legal commitment and privacy practices with respect to the information we collect and maintain about you. This office is required to abide by the terms of this notice and to notify you if we are unable to grant your requested restrictions or reasonable desires to communicate your health information by alternative means or to alternative locations. This office reserves the right to change its practices and effect new provisions that enhance the privacy standards of all patient medical information. In the event that changes are made, this office will notify you at the current address provided on your medical file. Other than for reasons described in this notice, this office agrees not to use or disclose your health information without your authorization.

To receive additional information or report a problem

For further explanation of this notice you may contact the Practice Administrator at 301-868-6700. If you believe your privacy rights have been violated, you have the right to file a complaint with your medical office or with the Secretary of Health and Human Services with no fear of retaliation by this office.

Your health information will be used for treatment, payment, and health care operations

Treatment – Information obtained by your health practitioner in this office will be recorded in your medical record and used to determine the course of treatment that should work best for you. This consists of your physician recording his/her own expectations and those of others involved in providing you care. The sharing of your health information may progress to others involved in providing you care. The sharing of your health information may progress to others involved in your care such as specialty physicians or lab technicians.

Payment – Your health care information will be used in order to receive payment for services rendered by this office. A bill may be sent to either you or a third-party payer with accompanying documentation that identifies you, your diagnosis, procedures performed, and supplies used.

Health Care Operations – The medical staff in this office will use your health information to assess the care you received, and the outcome of your case compared to others like it. Your information may be reviewed for risk management or quality improvement purposes in our efforts to continually improve the quality and effectiveness of the care and services we provide.

Problems or concerns: To file a complaint with the Secretary of Health and Human Services you may contact them at the address below:

Region III, Office of Civil Rights
US Dept of Health and Human Services
150 South Independence Mall West
Suite 372
Public Ledger Building
Philadelphia, PA 19106-9111
Phone: 1-800-368-1019
Fax: 215-861-4431

You will not be penalized for filing a complaint

X_____ X_____ X_____

Patient/Guardian Signature ***Date*** ***Patient/Guardian (Print Name)***

GREATER MARYLAND EYE PHYSICIANS & SURGEONS

AUTHORIZATION TO RECEIVE/RELEASE HEALTH INFORMATION

Due to the **HIPAA Compliance Privacy Laws of the Federal Government**, it is mandatory that we ask you to review and answer the following questions listed below.

Name: _____

May we leave messages/detailed medical information on voicemail at either of these phone numbers?

☐ Yes ☐ No **Home Phone**: _____ ☐ Yes ☐ No **Cell Phone**: _____

May we contact you at your place of employment? ☐ Yes ☐ No

If so, may we leave a message? ☐ Yes ☐ No

If yes: Work Phone: _____ Extension: _____

Do you have any particular person or family members that you authorize to receive and discuss information regarding your personal health information (general information, surgical, and billing)?

☐ Yes ☐ No If yes, please provide:

Name: _____ **Relationship**: _____

Phone Number: _____ **Alternate Number**: _____

Is this person your Power of Attorney for medical purposes? ☐ Yes ☐ No

Name: _____ **Relationship**: _____

Phone Number: _____ **Alternate Number**: _____

Is this person your Power of Attorney for medical purposes? ☐ Yes ☐ No

I hereby authorize GMEPS to obtain or release any and all pertinent information regarding my medical care, as needed to assist in my ongoing treatment to or from other health care providers, laboratories, radiology facilities or other institutions. **This authorization remains in effect until revoked**.

I have reviewed the **EXPLANTION OF REFRACTION TEST FEE Notice** and the **Notice of HIPAA Privacy Policy**. A copy of this policy will be provided to me upon request.

Patient Signature: _____ **Date**: _____

WITNESSED BY: _____

Reset Form