New Patient Information

Personal Information (Please Print)

Name ______________________ Date ______________
Date of Birth ____________ Age _____ M/F _____ Soc. Security ______________
Address ____
Street City State Zip
Email Address: ____

Phone: Home ( ) ________________ Work ( ) ________________
Cellular: ( ) ________________ Other phone: ( ) ________________
Occupation ________________ Employer ________________
Work Address: ____
Phone ( ) ________________ Ext. __________
Pharmacy Name: ________________ Pharmacy #: ________________
Marital Status: ( ) Single ( ) Married ( ) Widowed ( ) Divorced

Complete if under 18 years or a student:

Name of Father ________________ Employer ________________
Address ________________ Phone ( ) ________________
Name of Mother ________________ Employer ________________
Address ________________ Phone ( ) ________________
Policy Holder: ________________ Social : ________________

Insurance Information (Names Policy Holder): __________ **Social :** ________________

Primary Insurance: ________________ Effective Date: ________________
Policy Holder: ________________ Date of Birth: ________________
Social of Policy Holder: ________________ Relationship: ________________
Group #: ________________ ID# ________________
Tricare/ VA: Veteran's Name: ________________ Social : ________________
Secondary Insurance: ________________ Effective Date: ________________
Policy Holder: ________________ Date of Birth: ________________
Social of Policy Holder ________________ Relationship: ________________
Group # ________________ ID# ________________

Emergency Contact:

Name: ________________ Relationship: ________________
Home Phone: ( ) ________________ Work Phone ( ) ________________
Cellular Phone: ( ) ________________ Other Phone: ( ) ________________

Please answer the following questions about your medical status and history:

Height: ________ Weight: ________

Have you ever had any eye disease? ( ) Yes ( ) No
If YES, please explain: ____

Allergies and Reaction NKDA (no known allergies) _____ Latex Allergy? Y/N
If YES, please list: ____
____

Review of Systems:

Do you have or have you had any of the following:

Lung
() Bronchitis
() Emphysema
() Asthma
() TB
() Sinusitis
() Cold or Resp. Infections
() COPD
() Home Oxygen
() Sleep Apnea
() Use CPAP?
() None

Vascular
() High Blood Pressure
Is it Under Control ? Y/N
() Heart Attack
() Heart Murmur
() Rheumatic Fever
() Circulation Problems
() Heart Disease
() Chest Pain
() Sickle Cell
() Stroke
() Cholesterol
() Pacemaker
() Defibrillator
Has unit been interrogated in the last 3 months? Y/N
() None

CNS
() Polio
() Meningitis
() Parkinson's
() Migraines
() Seizures
() Alzheimer's
() Depression
() Anxiety
() Restless Leg Syndrome
() None

Endocrine
() Diabetes
Is it Under Control? Y/N
() Thyroid Problems
() Others - List
____
____
() None

Other
() Bladder Problems
() Kidney
() End Stage Renal Disease
On Dialysis? Y/N
If Yes, what days?
() HIV
() Alcohol
() Stomach
() Hiatal Hernia
() Peptic Ulcer Disease
() GERD
() Bowel
() Hepatitis/Jaundice
() Fainting
() Glaucoma
() Bleeding Problems
() Claustrophobia
() Other – List
____
() None

Family and Social History:

Do any medical or eye diseases run in your family (e.g., diabetes, high blood pressure, cancer, glaucoma, macular degeneration)? ( ) Yes ( ) No

If YES, please explain: ____
____

Do you smoke? ( ) Yes ( ) No
If yes, how many packs per day? ________

Do you drink alcohol? ( ) Yes ( ) No
If yes, how often? ______________

How Did You Hear About Us?

( ) Friend/Relative ( ) Newspaper ( ) Yellow Pages ( ) Television

( ) Doctor: ____________________________ ( ) Other: ____________________________

____

NAME AND PHONE NUMBER OF PRIMARY CARE PHYSICIAN

____

SIGNATURE DATE

Patient Name: ______________________________ Today's Date: ____/____/____

Date of Birth: ____/____/____

Allergies/Reaction: ____

____

Medications:
(Please include all over the counter medications, vitamins, supplements, etc.)

	Name of Medicine	Start Date / Stop Date	Tablet Strength	How to Use / When to Use	What is this Medicine for?
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					
16.					

☐ Not currently on medications.

We are committed to providing you with the best possible care. In order to better serve you, Oculoplastic and Orbital Consultants adopted the following policies. Please read the policies below so that misunderstandings can be avoided. If you have any questions, please feel free to speak with one of the staff members.

1. If we participate with your insurance plan and it requires a referral, you will be held responsible for obtaining the referral prior to your visit. All co-payments will be collected at the time of service. Please refer to your insurance company's provider directory to see if we participate with your plan.

   * Please remember: Your insurance policy is a contract between you, your employer and your insurance company. We are not a party to that contract. You are personally responsible for any bill, or portion thereof, not paid by a third party insurance carrier or Medicare.

2. If we do not participate with your insurance plan, you will be required to pay in full at the time of service, unless payment arrangements have been made prior to your visit. Our encounter form will serve as a receipt to submit to your insurance carrier.

3. We will file all third party insurances for surgical procedures. However, we require any insurance deductibles and/or co-payments be paid prior to the date of surgery.

4. For elective procedures not covered by insurance, payment in full is required prior to surgery. We will ***not*** file any elective procedure with any insurance carrier. There are no exceptions to this policy.

5. A service fee of $75.00 will be assessed for each returned check. Past due accounts greater than 30 days will be subject to an interest and bookkeeping late fee of 1.5% per month. Charges may also be made for broken appointments and appointments canceled without 24 hours notice. Past due accounts may/will be turned over to a national collection company after 3 months with a 35% surcharge.

6. In the event of repeatedly missed or broken appointments, Dr. Cowen reserves the right to discharge a patient from his care.

7. I will allow photographs to be taken and used at the discretion of Oculoplastic & Orbital Consultants.

Patient's Name: ____
(Please Print Name)

I have read the policies above and understand my responsibilities as a patient with the Oculoplastic & Orbital Consultants.

Signature ______________________________ Date ________________