Welcome To The Practice

Dear Patient,

Welcome to Capital Ophthalmology PLLC.

For safety, we recommend that someone drive you home from each visit.

Please bring the following to each visit:

- Your Drivers' License or Photo ID
- Your current health insurance cards
- Your prescription glasses
- A current list of your medications
- Sunglasses to wear after your appointment
- Your copay is required at the time of visit

Please review and fill out the attached forms, and please do not hesitate to ask any questions. We also need to know who your primary physician is, or any other doctors that may need reports.

We have a 24-hour cancellation policy. If you are unable to make your appointment and do not call within 24 hours, you will be charged a missed appointment visit fee.

We strive to make your visit to our office as enjoyable as possible. Please let us know if there is anything we can do to make your visit more pleasant.

Thank you so much!

The Doctors and Staff of Capital Ophthalmology

PATIENT REGISTRATION

Referred by:_____ **Family doctor:**_____

Patient Name._____ Today's Date_____
Last First Middle

Home Address_____

City_____ State_____ Zip Code_____

Home Phone_____ Cell Phone_____

E-mail address_____ Marital Status Single Married Divorced Widowed

Social Security Number_____ Date of Birth_____ Age _____ Gender M F

Employer/Parent's Employer_____ Occupation_____

Work Address_____ Work Phone_____

City_____ State_____ Zip Code_____

Spouse name (Parent name if minor)_____ Spouse/Parent Work Phone_____

Person to notify in case of emergency (other than spouse)_____

Phone number (s)_____ Relationship_____

Primary Insurance Company		
ID#	Group #	Effective Date
Subscriber Name		**Relationship to Patient**
Social Security Number	Date of Birth	Employer

Secondary Insurance Company		
ID#	Group #	Effective Date
Subscriber Name		**Relationship to Patient**
Social Security Number	Date of Birth	Employer

I certify that I (or my dependent) have insurance coverage as stated above and agree to have insurance payments made directly to (Practice Name) to be applied to my account for services rendered. I understand that I am financially responsible for all charges incurred in the event that my insurance denies payment. I am aware there may be additional collection and/or attorney's fees if my account is referred for collection. For patients covered by Medicare the patient will be responsible for 20% of the Medicare allowable charges plus any deductibles, coinsurance and uncovered charges that apply.

_____ _____

Patient's Signature **Today's Date**

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: _____

I hereby authorize Capital Opthalmology 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 aforementioned information and provide my consent regarding any and all the issues as stated above.

I have reviewed Capital Ophthalmology's Notice of HIPAA Privacy Policy. A copy of this policy will be provided to me upon request.

Patient Signature: _____ Date: _____

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Nickname: _____ Date of Birth: ____/____/_____

Primary Care Physician: _____ Referring /Specialty Dr._____

Pharmacy:_____ Location(street & city) _____

Race: ◻ American Indian or Alaska Native ◻ Asian ◻ Black or African American
◻ Native Hawaiian or Other Pacific Islander ◻ White

Ethnicity: ◻ Hispanic ◻ Not Hispanic

Preferred Language: ◻ English ◻ French ◻ Italian ◻ Japanese ◻ Portuguese
◻ Russian ◻ Spanish

Allergies:	**Reaction**	**Severity**
_____	_____	mild / moderate / severe
_____	_____	mild / moderate / severe
_____	_____	mild / moderate / severe
_____	_____	mild / moderate / severe

Past Ocular History: (Please mark all that apply) ◻ No history of eye problems

◻ Cataracts ◻ Hyperopia (Far sighted) ◻ Myopia (Near sighted) ◻ Amblyopia (Lazy eye)
◻ Diabetic Retinopathy ◻ Iritis ◻ Optic Neuritis ◻ Aphakia
◻ Dry Eyes ◻ Keratoconus ◻ Retinal Detachment ◻ Astigmatism
◻ Glaucoma ◻ Macular Degeneration

Other_____

Ocular Surgeries: (Please mark all that apply) ◻ No prior ocular surgery

R - L	R - L	R - L	R - L
◻ ◻ Foreign Body Removal	◻ ◻ Punctal Plugs	◻ ◻ Laser	◻ ◻ Cataract Surgery
◻ ◻ Blepharoplasty	◻ ◻ Retinal Laser Surgery	◻ ◻ RK	◻ ◻ LASIK/PRK
◻ ◻ Strabismus Surgery	◻ ◻ Vitrectomy	◻ ◻ Corneal Transplant	◻ ◻ Eye Muscle Surgery

Other_____

Current Eye Medications: (Please list)

_____ _____ _____
_____ _____ _____

Are you currently pregnant? Yes_____ No_____

Other Medical History: ◻ No history of illnesses

◻ Thyroid Disease ◻ Congestive Heart Failure ◻ Headache ◻ Lung Disease
◻ Anemia ◻ COPD ◻ High Blood Pressure ◻ Lupus
◻ Arthritis ◻ Diabetes Type 1 ◻ High Cholesterol ◻ Migraine
◻ Arrhythmia ◻ Diabetes Type 2 ◻ HIV/ AIDS ◻ Polymyalgia
◻ Asthma ◻ Eczema ◻ Kidney Disease ◻ Psychiatric Disorder
◻ Bleeding Disorder ◻ Fibromyalgia ◻ Kidney Stones ◻ Skin Cancer
◻ Cancer ◻ Hearing Loss ◻ Liver Disease ◻ Stroke
◻ Chicken Pox ◻ Herpes Zoster / Shingles ◻ Meningitis ◻ Toxoplasmosis
◻ Hepatitis A / B / C ◻ Histoplasmosis ◻ MRSA ◻ Wound Infection
◻ Herpes Simplex ◻ Syphillis

Other_____

General Surgeries / Operations: (Please list)

_____ _____ _____
_____ _____ _____

All Other Medications: (Please list)

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Please continue on the back side of this page →

Family History:

- ☐ Arthritis
- ☐ Blindness
- ☐ Cancer
- ☐ Cataracts
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Lazy Eye
- ☐ Macular Degeneration
- ☐ Retinal Disease
- ☐ Stroke
- ☐ TB

Other_____

Social History: (Please mark all that apply)

Smoking: ☐ current every day smoker ☐ current some day smoker ☐ former smoker ☐ never smoked

Alcohol Use: ☐ Yes ☐ No If yes how much and how often?_____

Drug Use: ☐ Yes ☐ No If yes what and how often?_____

Review of Systems

Eyes *

Previous Surgery	☐ YES	☐ NO
Contact Lens	☐ YES	☐ NO
Pain	☐ YES	☐ NO
Double Vision	☐ YES	☐ NO
Glaucoma	☐ YES	☐ NO
Cataracts	☐ YES	☐ NO
Macular Degeneration	☐ YES	☐ NO
Dry Eyes	☐ YES	☐ NO
Flashes	☐ YES	☐ NO
Floaters	☐ YES	☐ NO

Ear, Nose, and Throat *

Hard of Hearing	☐ YES	☐ NO
Ringing in Ears	☐ YES	☐ NO
Vertigo	☐ YES	☐ NO

Cardiovascular *

Chest Pain	☐ YES	☐ NO
Dizziness	☐ YES	☐ NO
Fainting Spells	☐ YES	☐ NO
Shortness of Breath	☐ YES	☐ NO
Irregular Heart Beat	☐ YES	☐ NO
Difficulty Lying Flat	☐ YES	☐ NO

Constitutional *

Fatigue/Weakness	☐ YES	☐ NO
Fever	☐ YES	☐ NO
Weight Gain/Loss	☐ YES	☐ NO

Respiratory *

Cough	☐ YES	☐ NO
Congestion	☐ YES	☐ NO
Wheezing	☐ YES	☐ NO
Asthma	☐ YES	☐ NO

Gastrointestinal *

Heartburn	☐ YES	☐ NO
Nausea/Vomiting	☐ YES	☐ NO
Jaundice/Hepatitis	☐ YES	☐ NO

Genito-Urinary *

Pain/Difficulty	☐ YES	☐ NO
Blood in Urine	☐ YES	☐ NO
History of Kidney Stones	☐ YES	☐ NO
History of STD's	☐ YES	☐ NO

Psychiatric *

Anxiety/Depression	☐ YES	☐ NO
Mood Swings	☐ YES	☐ NO
Difficulty Sleeping	☐ YES	☐ NO

Endocrine *

Increased Thirst	☐ YES	☐ NO
Increased Hunger	☐ YES	☐ NO
Increased Urination	☐ YES	☐ NO
Increased Sweating	☐ YES	☐ NO
Fingernail Changes	☐ YES	☐ NO

Blood/Lymphnodes *

Easy Bruising	☐ YES	☐ NO
Gums Bleed Easily	☐ YES	☐ NO
Prolonged Bleeding	☐ YES	☐ NO
Heavy Aspirin Use	☐ YES	☐ NO

MusculoSkeletal *

Stiffness	☐ YES	☐ NO
Arthritis	☐ YES	☐ NO
Joint Pain/Swelling	☐ YES	☐ NO
More than 2 falls in last y	☐ YES	☐ NO

Skin *

Rash/Sores	☐ YES	☐ NO
Lesions	☐ YES	☐ NO
Hives/Eczema	☐ YES	☐ NO

Neurological *

Seizures	☐ YES	☐ NO
Weakness/Paralysis	☐ YES	☐ NO
Numbness	☐ YES	☐ NO
Tremors	☐ YES	☐ NO

Immunologic *

Hives	☐ YES	☐ NO
Itching	☐ YES	☐ NO
Runny Nose	☐ YES	☐ NO
Sinus Pressure	☐ YES	☐ NO
Influenza vaccination?	☐ YES	☐ NO
Pneumonia vaccination?	☐ YES	☐ NO

REFRACTION SERVICES AND FEES

A refraction is the process of determining your best corrected vision and if there is a need for corrective eyeglasses or contact lenses. It is an essential part of the eye exam and is necessary to write a prescription for glasses or contact lenses.
A refraction is NOT a covered service by Medicare or most medical insurance plans. These plans consider a refraction a "vision" service not a "medical" service.

We will NOT file the charge for a refraction with a health insurance unless we know that your plan covers the refraction charge.

Our office fee for a refraction is $ 30 and this fee is collected at the time of service in addition to any co-payment your plan may require. Should your plan pay us for the refraction, we will reimburse you accordingly.

We cannot file insurance on both the medical and routine vision plan for the same visit.

_____ _____

Patient's Name (printed) **Date**

_____ _____ _____

Patient Signature (Legally responsible applicable) **Relationship to patient** **Staff Witness**

NEW YORK STATE OF OPPORTUNITY | Department of Motor Vehicles

VISION TEST REPORT

dmv.ny.gov

PATIENT INSTRUCTIONS:

a. Find a provider in DMV's Vision Registry at dmv.ny.gov/vision-registry-locator. If one of these providers completes your required vision test, you do not need this form to renew your driver license.

b. If your provider is not enrolled in DMV's Vision Registry, this report must be completed and used when renewing your license at dmv.ny.gov or by mail.

PROVIDER INSTRUCTIONS:

a. **This form should be used only for patients who have a minimum Snellen Test score of 20/40 with one or both eyes, with or without corrective lenses.** For patients whose best corrected vision is less than 20/40 but not less than 20/70, and for patients who wear telescopic lenses, complete form MV-80L (dmv.ny.gov/forms) and mail it to the address on that form.

b. ONLY a licensed physician, physician assistant, registered nurse, nurse practitioner, optician, optometrist, ophthalmologist, or supervised staff of any of these providers can complete the MV-619.

c. PRINT in ink or TYPE all information below except signature.

d. Do not mail this report. Give it to the patient.

e. To enroll in DMV's Vision Registry, please visit dmv.ny.gov/visionprovide.htm. It's simple, easy and free!

1. Patient's Name (exactly as it appears on the patient's driver license) Last First MI	2. Date of Birth (MM/DD/YY) / /	3. Sex ☐ M ☐ F
4. Patient's Street Address		Apt. #
City State Zip Code	5. Date of Examination (MM/DD/YY) / /	
6. Did the patient achieve a Snellen Test score of 20/40 or better with one or both eyes? ☐ YES ☐ NO If NO, complete form MV-80L		
7. Did the patient wear corrective lenses during the test? ☐ YES ☐ NO		
8. Name and Title of Provider		
9. Provider's Street Address		
City State Zip Code		
10. This report is valid for up to ☐ 12 months ☐ 6 months from the date of examination.		
11. *I have examined the patient described above, and have accurately reported my findings from that examination on this form.* Provider's Signature (Sign Name in Full) Sign Here ✍		12. Professional License No.