PATIENT INFORMATION

DATE:		PRIMARY CARE DOCTOR:
LAST NAME:	FIRST NAME:	MIDDLE NAME:
MARITIAL STATUS: (CIRCLE ONE) SINGLE / MARRIED / DIVORCED / SEPERATED / WIDOW		(CIRCLE ONE): MALE / FEMALE
SOCIAL SECURITY:	DATE OF BIRTH: / /	AGE:
STREET ADDRESS:	CELL PHONE:	HOME PHONE:

P.O. BOX:	CITY:	STATE:	ZIP CODE:

OCCUPATION:	EMPLOYER:	EMPLOYER PHONE:
REFERRED TO CLINIC BY:	OTHER FAMILY MEMBERS SEEN HERE:	

INSURANCE INFORMATION

PRIMARY INSURANCE:	POLICY HOLDER'S NAME:	DATE OF BIRTH: / /
MEMBER ID #:	GROUP #:	RELATIONSHIP TO POLICY HOLDER: SELF / SPOUSE / CHILD / OTHER
SECONDARY INSURANCE:	POLICY HOLDER'S NAME:	DATE OF BIRTH: / /
MEMBER ID #:	GROUP #:	RELATIONSHIP TO POLICY HOLDER: SELF / SPOUSE / CHILD / OTHER

IN CASE OF EMERGENCY

NAME:	RELATIONSHIP:	CELL PHONE:	HOME PHONE:

Signature on File: (1) I authorize the use of my signature on all of my insurance submissions, (2) release of information to all of my insurance companies, (3) my doctor to act as my agent in helping me obtain payment from my insurance carrier, (4) payment directly to my doctor and (5) a copy of this authorization in place of the original.

I understand that (1) I am responsible for my bill, (2) that if my account is turned over to collections, there will be a **31%** charge added to my bill, (3) there will be a **$35.00** charge to my account for all returned checks and (4) missed appointments (no-shows) will be charged a fee of **$50.00**.

Medicare will only pay for services it determines to be "reasonable and necessary" under section 1862a1 of Medicare Law. If Medicare and/or other insurance companies determine a particular service is not covered, **you will be responsible for that service.** Medicare and some other insurances may deny payment for routine eye examinations and refractions. **Eyeglasses, contact lenses and measurements will be an out of pocket expense for ALL patients.**

BENEFICIARY AGREEMENT: I have read and understand the above information.

SIGNATURE OF RESPONSIBLE PARTY: DATE: / /

Name_____ Age_____ Today's Date_____

Eyes

Previous surgery	☐Yes ☐No
Contact lens	☐Yes ☐No
Pain	☐Yes ☐No
Double vision	☐Yes ☐No
Glaucoma	☐Yes ☐No
Cataracts	☐Yes ☐No
Macular Degen.	☐Yes ☐No
Dry eyes	☐Yes ☐No
Redness	☐Yes ☐No
Tearing	☐Yes ☐No
Blur	☐Yes ☐No
Flashes/Floaters	☐Yes ☐No

Ear, Nose, and Throat

Hard of hearing	☐Yes ☐No
Ringing in Ears	☐Yes ☐No
Vertigo	☐Yes ☐No
Pain on chewing	☐Yes ☐No
Sore throat	☐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
Palpitations	☐Yes ☐No

Constitutional

Fatigue/Weakness	☐Yes ☐No
Fever	☐Yes ☐No
Weight Gain/Loss	☐Yes ☐No

Are you Diabetic? ☐Yes ☐No
BSL_____ Type_____

Respiratory

Cough	☐Yes ☐No
Congestion	☐Yes ☐No
Wheezing	☐Yes ☐No
Asthma	☐Yes ☐No
Shortness of breath	☐Yes ☐No
Sneezing	☐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
Dysuria	☐Yes ☐No
Difficulty with urine flow	☐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
Heat or Cold Intolerance	☐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
Shoulder pain	☐Yes ☐No

Skin

Rash/Sores	☐Yes ☐No
Lesions	☐Yes ☐No
Hives/Eczema	☐Yes ☐No
Itchy Eyes	☐Yes ☐No
Scalp tenderness	☐Yes ☐No

Neurological

Seizures	☐Yes ☐No
Weakness or Paralysis	☐Yes ☐No
Numbness	☐Yes ☐No
Tremors	☐Yes ☐No
Difficulty speaking	☐Yes ☐No

Immunologic

Hives	☐Yes ☐No
Itching	☐Yes ☐No
Runny nose	☐Yes ☐No
Sinus Pressure	☐Yes ☐No

TURN OVER→

Do you smoke? ☐Yes ☐No *if yes, how often _____
Do you drink alcohol? ☐Yes ☐No *if yes, how often_____

Medical History

Check off any Medical Problems:

☐ Premature Birth ☐ Diabetes ☐ Hypertension (High Blood Pressure) ☐ Thyroid Disease

☐ Cancer (Type: _____ Are you currently undergoing chemotherapy? ☐Yes ☐No)

List any other medical problems that other doctors have diagnosed:

Surgeries

Year	Reason

Other hospitalizations

Year	Reason

Preferred Pharmacy :	Phone:	Fax:
Address	Zip Code:	

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers:

Name of the Drug	Strength	Frequency Taken

Allergies to medication:

Name of Drug	Reaction you had:

Family History

Do you have any family members with Glaucoma?	☐ Yes	☐ No
If yes, what is their relationship? (i.e. mother, father, etc.)		
Do you have any family members with Lazy Eye or Crossed Eyes?	☐ Yes	☐ No
If yes, what is their relationship? (i.e. mother, father, etc.)		

Print Name: **Date:**

Paul S. Cunningham, M.D.
Sarah B. Mahmoud, O.D., F.A.A.O
9131 Piscataway Rd Suite 650
Clinton, MD 20735

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/LIMITEDAUTHORIZATION& RELEASE

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date_____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this health care facility. A copy of the signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMNENT RELEASE SHOULD I REQUEST TREATMENT, TESTS OR RADIOGRAPHS BE SENT TO OTHR ATTENDING DOCTOR/FACILITIES IN THE FUTURE.

_____ _____
Print full name of patient/Guardian Sign patient's name /Guardian name

_____ _____
Legal Representative/Guardian Relationship of Legal Rep/ Guardian

Your comments regarding Acknowledgements or Consent:_____

_____

If you do not want to be addressed by Proper Surname (last Name), how do you want to be addressed:

- First Name _____
- Other_____

PLEASE LIST ANY OTHER PARTIES WHO YOU WISH TO HAVE ACCESS TO YOUR HEALTH RECORDS/INFORMATION:

Name_____ Relationship_____

Name_____ Relationship_____

I Authorize contact from this office to confirm my appointments, treatment, & Billing information VIA:

Work_____ Cell_____ Home_____ Other_____

I AUTHORIZE INFORMATION ABOUT MY HEALTH BE CONVED VIA:

Work_____ Cell_____ Home_____ Other_____

In signing this HIPPA Patient Acknowledgement Form, you acknowledge an authorize, that this office may recommend products or services to promote your improved health. This Office may or may not receive third-party remuneration from these affiliated companies. We, under current HIPPA Omnibus Rule, Provide you this information with your knowledge and consent.

Office use ONLY

As Privacy officer, I attempted to obtain the patients (or representatives) Signature on this Acknowledgement but did not because:

It was an emergency treatment_____
I could not communicate with patient _____
The Patient refused to sign_____
The Patient was unable to sign _____
Other (Please describe) _____

_____
Signature of Privacy Office