PLEASE FILL OUT ALL QUESTIONS

Patient Name:			
Last:		First:	MI:
Circle One:	Married Single Other	**Sex:**	Male Female
Street Address:			
City:		State:	Zip:
Home #:	( )	**Other #:**	
Cell #:	( )		
Email:			
Patient DOB:		**Patient SS:**	
Place of Employment:			

INSURANCE INFORMATION:

Your insurance requires us to verify your coverage at every visit.
You must present a card at EVERY visit.
If you forgot your insurance card we will need to reschedule your appointment.
Insurance companies may request PHOTO ID for verification.

PRIMARY

Insurance Company:		
Is the insurance thru you?	**YES**	**If NO: Insured Name:**
		If NO: Insured SS#:
		If NO: Insured DOB:

SECONDARY

Insurance Company:		
Is the insurance thru you?	**YES**	**If NO: Insured Name:**
		If NO: Insured SS#:
		If NO: Insured DOB:

Primary Care Physician:			
Street Address:		Phone:	( )
City, State, Zip:			
Referring Physician:			
Street Address:		Phone:	( )
City, State, Zip:			

If not referred by a doctor, how did you hear about us?

☐	Insurance directory/list	☐	Website
☐	Phone book	☐	Newspaper
☐	Other:		
☐	Patient:		

PATIENT NAME: ______________________ AGE: ________ DOB: ____________________

Your insurance requires us to review this information with you. Please fill out completely if you are using your insurance as part of your payment for your visit today.

What problem or concern brings you to our office?

Do you want a routine vision exam? YES NO

Date of your last routine vision exam:

** Routine vision is not covered by Medicare or many other standard medical plans. Let us know if you have a vision benefit, we do take several vision plans

PRIMARY CARE DOCTOR:

LIST CURRENT MEDICATIONS, INCLUDING VITAMINS AND EYE DROPS		
MEDICATION	STRENGTH (MG, CC)	DOSAGE (TIMES PER DAY)
1.		
2.		
3.		
ADDITIONAL SPACE PROVIDED ON BACK		

LIST PAST MEDICAL HISTORY; ILLNESSES, HOSPITALIZATION, SURGERY	
DATE:	SERIOUS ILLNESS, HOSPITALIZATION, SURGERY
ADDITIONAL SPACE PROVIDED ON BACK	

ARE YOU ALLERGIC TO ANY MEDICATIONS OR MEDICAL DEVICES?	
MEDICATION	REACTION
1.	
2.	
3.	

DO YOU HAVE:		
Diabetes	YES	NO
Glaucoma	YES	NO
Retinal/Macular Problems	YES	NO
Cataract	YES	NO
Lazy Eye	YES	NO
Other Eye Disease		

DO ANY OF YOUR FAMILY MEMBERS HAVE:			LIST FAMILY MEMBERS:
Diabetes	YES	NO	
Retinal/Macular Problems	YES	NO	
Glaucoma	YES	NO	

REVIEW OF SYSTEMS (must circle either yes or no)						
Do you have….	Unexplained weight loss/gain	YES	NO	Shortness of Breath	YES	NO
	Difficulty hearing	YES	NO	Rash	YES	NO
	Chest pain	YES	NO	Headaches	YES	NO
	Diarrhea	YES	NO	Depression	YES	NO
	Difficulty Urinating	YES	NO	Nausea/vomiting	YES	NO
	Joint pain	YES	NO	Unexplained bruising	YES	NO
	AIDS	YES	NO	Hepatitis	YES	NO
Are you:	Pregnant	YES	NO	Blurry Vision	YES	NO
Social History	Smoker	YES	NO	Alcohol	YES	NO
	Recreational Drug Use	YES	NO			

Sheet 1A
Date:

Reviewed By: Physician____________________
Wesley J. Harnish, MD/Tatiana Hammond, OD/Mary Furgerson, OD

PATIENT NAME: ____________________ AGE: ________ DOB:____________

LIST CURRENT MEDICATIONS, INCLUDING VITAMINS AND EYE DROPS		
MEDICATION	STRENGTH (MG, CC)	DOSAGE (TIMES PER DAY)
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
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26.		
27.		

LIST PAST MEDICAL HISTORY;	
DATE:	SERIOUS ILLNESS, HOSPITALIZATION, SURGERY

Date:

Reviewed By: Physician____________________________________
Wesley J. Harnish, MD/Tatiana Hammond, OD/Mary Furgerson, OD

Eye Surgical & Medical Care

FINANCIAL POLICY

We are committed to providing you with the highest level of service and quality care. If you have medical insurance, we will strive to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our financial policy. Ultimately all financial liability rests with the patient.

INSURANCE AND PAYMENT AGREEMENT

I authorize Medicare and/or my private insurance company to pay Wesley J. Harnish, MD dba Eye Surgical & Medical Care for all services provided to me.

I will bring all current insurance information to each office visit and notify the office immediately of any changes to my coverage.

I am responsible for knowing and complying with the requirements and restrictions of my insurance plan.

If my insurance plan requires a referral to seek care from a specialist (Dr. Harnish is a specialist,) I will obtain it prior to my scheduled appointment.

In accordance with my insurance contract, I will pay all co-payments and deductibles on the day I receive service.

Any portion of my bill that is "patient responsibility" and is billed to me will be received by the due date printed on the statement (term 30). If the balance is not received by the due date a $25.00 statement fee will be added to my account and due immediately.

Any payment made by check that does not clear my bank will be assessed a $50.00 fee, which will be added to my account and will be due immediately.

I understand that any outstanding balance considered past due will be processed for collection. An account recovery fee of $50.00 will be added to my balance sent to collection. A collection account may be sent to a collection agency and reported to the appropriate credit bureau(s).

I understand that by signing below, I agree to these terms for the duration of my relationship with Wesley J. Harnish, MD. dba Eye Surgical & Medical Care.

Patient/Guardian Signature:____

Eye Surgical & Medical Care has always carefully protected our patients' private medical record and personal information.

In 2003 the Federal Government enacted the Health Insurance Portability and Accountability Act. In order to comply with this regulation we must have you complete the form below.

Our office will honor the requests below until the patient notifies us in writing of a change in status.

Patient Name:			
Date of birth:		Today's Date	

√ **You must Check one:**

☐ Please do not release my information to anyone except those required by law. Only you may call for appointment scheduling, refills, and etcetera.

☐ Please release my information to anyone who requests it.

☐ Please release my information to the following individuals:

	Name	Phone Number
1.		
2.		
3.		
4.		
5.		

I have received a copy of ESMC's Notice of Privacy Practices

Patient Signature:____

Wesley Harnish, MD
Tatiana Hammond, OD
Mary Furgerson, OD

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