NEW PATIENT INFORMATION

Patient Name:
Mrs. Mr. Miss
Dr. Rev. Ms. _____
FIRST M IDDLE LAST

Address: _____
STREET

_____
CITY STATE ZIP CODE

Home Phone: _____ Cell Phone: _____

Date of birth: _____ Social Security #: _____

Spouse's Name: _____ Family Doctor: _____

Who referred you to our office? _____

Employer:_____

Employer Address: _____

Employer Phone: _____ Extension_____

Person we can contact in an emergency (please include phone number):

_____

The following will not be released to any source without your consent.

Explain the problem you are having with your eyes: _____

_____

Do you have a hearing problem? _____

Do you have any allergies to medications? (please list): _____

_____

List all prescription medications you are taking: _____

_____

NEW PATIENT INFORMATION

Do you currently smoke or use any tobacco products? No_____ Yes _____

If yes, for how many years? _____

If you smoked or used tobacco products in the past, when approximately did you discontinue?
_____

Do you drink alcohol? No_____ Yes _____If yes, how often? Please specify:

Rarely ___ Weekly ___ Daily ___ Other _____

Do you use illegal drugs? No_____ Yes _____

Have you been exposed to HIV? No_____ Yes _____

Have you been exposed to other sexually transmitted diseases? No_____ Yes _____

Please specify if you have any of the following:

Glaucoma_____ Diabetes_____ High blood pressure_____

Cataract_____ Lazy eye_____ Heart Disease_____

Bleeding Disorder_____ HIV/AIDS_____ Lung disease_____

Other_____

Prostate enlargement/disease or cancer _____

If yes, are you currently or in the past treated by Flomax (tamsulosin) No___ Yes ___

Any herbal or over-the-counter medications for this problem? No_____ Yes _____

If yes, please list _____

Have you had any past eye surgeries or injuries? If so, please describe:
_____

_____

_____

To the best of your knowledge, do any of your blood relatives have the following:

Macular degeneration_____ Cataract_____ Corneal disease_____ Glaucoma_____

If any member of your family has glaucoma, please specify who:_____

NEW PATIENT INFORMATION

Please provide our office with a list of persons (if any) with whom we may discuss your medical care, such as a spouse, caregiver, etc. (Not including your family doctor)

NAME	RELATIONSHIP TO YOU
1._____	_____
2._____	_____
3._____	_____
4._____	_____

Patient Signature: _____

POA/Guardian:_____

Date: _____

INSURANCE FINANCIAL LIABILITY ACKNOWLEDGEMENT FORM

Elmwood Eye Center
Brian L. Vitz, D.O.
1601 Second Avenue
York, PA 17403

Patient's Name:_____**ID#:**_____

Insurance Plan:_____**Provider ID#:**_____

Our office is required to notify all medically insured patients and patients who qualify for medical assistance or are covered by a commercial medical assistance plan of any service(s) that could be the patient's financial liability, prior to rendering services(s).

LIST OF SERVICES/PROCEDURES/SUPPLIES:

____Refraction or prescription of spectacles or an update of your current spectacles.
____Supplies provided by our office, including but not limited to post-operative kits following cataract surgery and bandage contact lenses.
____Other:_____

You may be responsible for the above listed services(s) due to the following reason(s):
(Check one)

___ Medicare, your insurance plan or medical assistance plan does not pay for a non-covered service(s) or supplies. For patients covered by a commercial plan, see your Evidence of Coverage for a complete listing of non-covered services and supplies.
___ The service or supplies(s) is not covered without a Referral from your Primary Care Physician.
___ The service or supplies is not covered because it is investigational.
___ The service(s) or supplies is not covered unless it is due to an emergency.

Note: This form is invalid if the service(s) is not specified in the spaces above prior to the execution of this form.

BENEFICIARY AGREEMENT

I have been notified by the provider identified above that the requested service(s) is not covered by my insurance plan or medical assistance and medical assistance commercial plans for the reason(s) stated above. I understand that I may be fully responsible for payment.

SIGNED:_____DATE:_____
(Beneficiary Signature)

ELMWOOD EYE CENTER
BRIAN L. VITZ, D.O.
1601 SECOND AVENUE
YORK, PA 17403
(717) 848-2520

RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Acknowledgement

Our Notice of Privacy Practices provides information about how we may use and disclose health information about you. You have the right to review our notice and ask questions about our privacy practices. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by_____.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement. By signing this form, you acknowledge that you have received our Notice of Privacy Practices.

Patient Signature: _____

POA/Guardian:_____

Date: _____

NEW PATIENT INFORMATION

INSURANCE AND PAYMENT OF SERVICES INFORMATION

We participate with several insurance companies. If you are a member of any of these plans, we will make a copy of your insurance cards for our records. If your insurance company covers provided services, we will forward charges to your carrier. However, payment of any non-covered services is requested at time of service.

If we do not participate with your insurance carrier, payment is required at time of service. We will provide you with a detailed receipt that outlines your visit and contains all information needed for processing by your carrier.

MEDICARE PATIENTS

NAME_____HIC#_____PART B___

I request that payment of authorized Medicare benefits be made to Brian L. Vitz, D.O. on my behalf for services furnished me by above physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agencies any information needed to determine these benefits or the benefits payable to related services.

NON-MEDICARE PATIENTS AND SECONDARY CARRIERS

INSURED NAME_____ CARRIER_____

I.D. #_____ GROUP #_____

INSURED S.S. # _____-_____-_____

I request that payment of authorized benefits from my insurance company of Medigap company be made to Brian L. Vitz, D.O. on my behalf for services furnished me by above physician. I authorize any holder of medical information about me to release to above named carrier any information needed to determiner these benefits payable to related service.

ALL PATIENTS

PATIENT (or authorized person) SIGNATURE_____

PRINT PATIENT NAME_____

DATE_____