SHADY GROVE OPHTHALMOLOGY™

REGISTRATION FORM

DATE: ________________

Last Name: ______________________________ **First Name:** __________________________________ **MI:**____

DOB: __________ **Age:** ____ **Gender:** M / F **Marital Status:** Single / Married / Other **SSN** __________________

Address: ____ **Apt#:** ____________

City/State/Zip: ____

Home #: ____________________ **Cell #:** ________________________ **Work#:** __________________________

Please Circle Preferred Contact Method: Home # / Cell # / Work # **Is it Ok to leave a Voice Mail?** Yes / No

Email Address: _________________________________

Employer: ____________________________________ **Occupation:**___________________________________

Emergency Contact: __________________________ **Relationship:** ________________ **Phone:**_______________

If you would like us to update your PCP or referring doctor regarding your medical status, please fill out this information

Primary Care Physician: ______________________________ **Primary Care Physician Phone:**_______________

Referring Physician: _________________________________ **Referring Physician Phone :**________________

PHARMACY INFORMATION:

Pharmacy Name: ________________________________ City: _______________________________________

Pharmacy Phone #: ______________________________ Pharmacy Fax #: ______________________________

As a courtesy to you we are able to send prescriptions directly to your pharmacy before the end of your visit.

INSURANCE INFORMATION

Primary Insurance: ____________________________

ID#: ________________________ **Group #:** _______

Policy Holder's Name: __________________________

Date of Birth: ______________ **SS#:** ____________

Relationship to Patient: _______________________

Secondary Insurance:___________________________

ID#: __________________________ **Group:** _________

Policy Holders Name:_____________________________

Date of Birth: ____________ **S#:**___________________

Relationship to Patient:___________________________

INFORMATION OF RESPONSIBLE PARTY (FOR MINORS)

Parent Name: __________________________________ **Date of Birth:** ______________ **SS#:** ______________

Address____

Home #: ____________________ **Work #:** ______________________ **Employer:**_________________________

Race:

White/Caucasian
African American
American Indian
Other
Alaska Native
Asian

Ethnicity:

Hispanic/ Latino
Non-Hispanic Or Latino
Unknown

HOW DID YOU HEAR ABOUT US:

Friend/Family:_______________ Internet:____________

Doctor:______________ Doctors Phone______________

Other:___________________________

REFRACTION POLICY (GLASSES PRESCRIPTION)

Eye examinations have two portions, the medical eye exam and the refraction. The refraction is the measurement taken to determine if there is a need for glasses and if so, your glasses prescription. Refractions may be done for routine eye exams (Vision plans) or medical exams (medical insurance).
Most insurance plans including Medicare do not pay for refractions. **Our refraction fee is $45.00.**

Patients or Guardian Signature: ______________________________________ **Date:** ______________

V.B.25

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Todays Date:_____________

Medical History Form

Last Name: ______________________________ **First Name:**_________________________ **Date Of Birth:** ___________

Review of Systems:

Do you currently have any of the following problems: (Please check ALL that apply)

Blurry Vision __
Sandy Sensation __
Eye Pain __
Excessive Tearing __
Redness __
White Flashes __
Floaters __
Sensitive to Light __
Glare __
Loss of Vision __
Stye __

Tired eyes __

Seizures __
Foreign body sensation __
Contact lens discomfort __
Mucous in eyes __
High Blood Pressure __
Arthritis __
Headaches __
Scalp Tenderness __
Anxiety __
Depression __
Diabetes __ Last A1C level ____________

Other____

Seasonal Allergies __
Ear Ache __
Jaw Pain __
Weight loss __
Cough __
* Do you take Plaquenil? Y /N

Medical History:
What medical conditions do you have?

Are You Pregnant? Yes / No **Are you Planning a Pregnancy? Yes / No**

____
____
____

Major Surgeries:____

Past Eye History:

Have you ever been diagnosed with having:

__ Cataract
__ Glaucoma
__ Macular degeneration
__ Diabetic Retinopathy
__ Retinal detachment
__ Dry Eyes

List any EYE surgeries you have had in the past (Cataract, Glaucoma, Refractive)

__________________________________ Eye: right / left When?___________
__________________________________ Eye: right / left When?___________
__________________________________ Eye: right / left When?___________

Do you wear __ Glasses __ Contact Lenses

Family Eye History: (Please check ALL that apply)

__Glaucoma __Blindness __Hypertension __ Retinal Detachment __ Heart Disease

__ Cataract __ Diabetes __ Macular Degeneration __ Cancer __ Strabismus

Social History:

Smoking Status:	**Exercise:**	**Caffeine:**	**Alcohol:**	**Driving Status:**
__ Current/Everyday	__ Several times a day	__ Several times a day	__ 3 or more drinks/Daily	__ Drives at Night
__ Current/Some Days	__ Once a day	__ Once a day	__ 1-2 drinks/Daily	__ Drives in Daytime
__ Former Smoker	__ Few times a week	__ Few times a week	__ Less than 1 drink/daily	
__ Never	__ Few times a month	__ Few times a month	__ Occasionally	
	__ Never	__ Never	__ None	

Medications:
____
____
____
____
____

Eye Drops:
____
____
____
____
____

Allergic To ANY Medications:
____
____
____
____
____

SHADY GROVE OPHTHALMOLOGY™

FINANCIAL POLICIES:

REFRACTION-GLASSES PRESCRIPTION: Eye examinations have two portions, the medical eye exam and the refraction. The refraction is the measurement taken to determine if there is a need for glasses and if so, *your glasses prescription.* Refractions may be done for routine eye exams (Vision plans) or medical exams (medical insurance). Most insurance plans, including Medicare do not pay for refractions. We do not accept Vision Plans therefore, **Our Refraction fee is $45.00.**

HMO PLANS/REFERRALS: Managed care plans require a valid referral at the time of service. It is our policy that patients are responsible for obtaining necessary referrals for any office visits or procedures from their primary care physician. Referrals must be in hand at the time of the exam or procedure. We accept faxed referrals from the primary physician's office prior to the appointment. If you do not have a referral at the time of your visit your appointment can be rescheduled until you obtain a referral. For your courtesy, you can sign a waiver form and be required to submit a referral within 48 hours of your appointment. The referral is your responsibility. If you choose to be seen without a referral or fail to inform us of any changes to your health insurance coverage, group number, or ID number, you are responsible for any charges due in full at the time of service.

BILLING QUESTIONS/PAYMENTS: Please Contact Carrie at our Billing office (301) 762-0459

CONTACT LENSES: In most cases medical insurance and routine vision plans do not cover the cost of a contact lens evaluation, prescription verification, or fitting. The charge for a contact lens training is $150.00. This covers proper training on contact lens insertion, removal, and care for first time users, *which requires a second appointment.* If the patient requires more than 1 hour for training, we offer a second session at half price.

SELF PAY /NO INSURANCE: If you are the sole party responsible for all charges incurred, we ask that you make your payments at the time of service. If your treatment is extensive, or you require any type of surgical procedure including any refractive procedures, we offer 0% financing for up to 12 months with Care Credit.

NO SHOW/LATE/CANCELLATION: We request that you keep scheduled appointments and arrive on time. Cancellations of less than 24 hours prior to your appointment, or No- Show for your appointment will result in a $40 fee. If you are going to be late please notify us as soon as possible so we can attempt to make appropriate accommodations. If more than 15 minutes late, you may be asked to reschedule your appointment.

MVA AND OTHER FORMS: We will charge a $15.00 fee for MVA forms to be filled outside of your appointment. Any other forms that require the doctor's signature and review will also be a $15.00 fee. This service will not be billed to your account or your insurance company. Payment is due before the form(s) will be released. A receipt will be provided at the time of payment.

REQUEST FOR MEDICAL RECORDS: Requests for copies of medical records must be made in writing or by filling out our Medical Records Release Form. Copies of medical records can be made for a fee of $25.00.

WORKERS COMP: You will need to bring the following information: Case Number; Address of the claim company; Name and contact phone number of the person assigned to the claim. If you do not have all of this information, you will be held accountable for exam cost and reimbursed if and when information is obtained.

REFRACTIVE LENS EXHCHANGE, LASIK, PRK: These are surgical procedures done after being evaluated and approved by the doctor. Appropriate to patients who want freedom from glasses and contacts. This is not covered by insurance and we charge a down payment of $150 to secure your surgery appointment, this will be applied to the surgical cost. This is due when scheduling surgery appointment.

I, ________________________________ have read and understood Shady Grove Ophthalmology's policies, and have discussed any questions to their staff.

Anthony O. Roberts, MD
9715 Medical Center Dr, Suite 502
Rockville, MD 20850
P: (301)279-2770 F: (301) 294-5322 www.ShadyGroveOphthalmology.com

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Anthony O. Roberts, M.D. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Anthony O. Roberts, M.D. office's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review Notice of Privacy Practices prior to signing this consent. Anthony O. Roberts, M.D. reserves the right to revise its Notice of Privacy Practices at any time. A Notice of Privacy Practices may be obtained at any time during your visit.

With my consent, Anthony O. Roberts, M.D. may call my home or other designated location and leave a message on voicemail or in person in reference to any items that assist the office in carrying out treatment, payment or other health care operation (TPO). Such as post operative telephone calls, insurance items, or any call pertaining to my clinical care.

With my consent, Anthony O. Roberts, M.D. may mail or fax to my home or other designated location any items that assist the office in carrying out treatment, payment or healthcare operation (TPO), such as patient statements.

By signing this form, I am consenting to Anthony O. Roberts, M.D. offices disclosure of my protected health information (PHI) to carry out treatment, payment, or other healthcare operations (TPO).

I may revoke my consent in writing except to the extent that the office has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Anthony O. Roberts, M.D. may decline to provide treatment to me.

____
Print Name of Patient or Legal Representative

____
Signature of Patient or Legal Representative

____
Date

I have received a copy of the Patient Bill of Rights

SHADY GROVE OPHTHALMOLOGY™

Name: ____________________________________ Date: __________________

Thank you for choosing Shady Grove Ophthalmology!

Did a doctor refer you to us? ____ Yes ____ No

If yes, please tell us who referred you:

Optometrist ____

Family Doctor ____

Specialist ____

Did you hear about us in any of the following way?

Please check all that apply

____ Facebook ____ Rating Site (Yelp, Health grades, etc..)

____ Google ____ Insurance Website/ Physician Finder

____ Family or Friend Name: _______________________________________

____ Zoc Doc ____ Washington Redskins Promotion

____ Group On

Did you visit our website before making your appointment?

____ Yes ____ No

Thank You!