SHADY GROVE OPHTHALMOLOGY™

-REGISTRATION FORM- DATE: _____

Last Name: _____ **First Name:** _____ **MI:**____

DOB: _____ **Age:** ____ **Gender:** **Marital Status:** **SSN** ___

Address: _____ **Apt#:** _____

City/State/Zip:_____

Home #: _____ **Cell #:** _____ **Work#:**_____

Appointment Confirmation System: Circle Preferred Contact Method**:** Home ◯ / Cell ◯ / Work ◯

Is it Ok to leave a Voice Mail? ◉Y ◯ N **Text?** ◉ Y ◯ N **Email Address :**_____

Employer: _____ **Occupation:**_____

Emergency Contact: _____ **Relationship:** _____**Phone:**_____

Authorized Person to discuss Medical information with:_____ **Phone:**

We would like to update your primary 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: _____ Address/City: _____

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

INSURANCE INFORMATION (IF POLICY HOLDER IS DIFFERENT FROM PATIENT)

Primary Insurance: _____

ID#: _____ **Group #:** _____

Policy Holder's Name: _____

Date of Birth: _____ **SS#:** _____

Relationship to Patient: _____

Secondary Insurance:_____

ID#: _____ **Group:** _____

Policy Holder'sName:_____

Date of Birth: _____ **SS#:**_____

Relationship to Patient:_____

INFORMATION OF RESPONSIBLE PARTY (FOR MINORS)

Parent Name: _____ **Date of Birth:** _____ **SS#:** _____

Address_____

Home #: _____ **Work #:** _____ **Employer:**_____

Race: _____

Ethnicity: _____

HOW DID YOU HEAR ABOUT US:

Name of Friend:_____ Internet:_____

Doctor:_____ Doctors Phone_____

Other:_____

ACKNOWLEDGEMENT OF 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*. We do not accept Vision Plans. This will be up to the doctor and the patient during the exam.

Our refraction fee is $75.00.

Patients or Guardian Signature: _____ **Date:** _____

updated 3/18/2021

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Todays Date:_____

Medical History Form

Last Name: _____ First Name:_____ DOB: _____

Review of Systems:

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

Blurry Vision	☐	Seizures	☐		
Sandy Sensation	☐	Foreign body sensation	☐	Seasonal Allergies	☐
Eye Pain	☐	Contact lens discomfort	☐	Ear Ache	☐
Excessive Tearing	☐	Mucous in eyes	☐	Jaw Pain	☐
Redness	☐	High Blood Pressure	☐	Weight loss	☐
White Flashes	☐	Arthritis	☐	Cough	☐
Floaters	☐	Headaches	☐	Do you take Plaquenil?	☐
Sensitive to Light	☐	Scalp Tenderness	☐	On Dialysis	☐
Glare	☐	Anxiety	☐	Atrial Fibrillation	☐
Loss of Vision	☐	Depression	☐	Pacemaker	☐
Stye	☐	Diabetes ☐	Last A1C level _____		
Tired eyes	☐	**Other**_____			

Medical History: **Are You Pregnant?** Yes ☐ No ☐

What medical conditions do you have?

_____

_____

_____

Major Surgeries:_____

Past Eye History:

Do you have...

- ☐ Cataract
- ☐ Glaucoma
- ☐ Macular degeneration
- ☐ Diabetic Retinopathy
- ☐ Retinal detachment
- ☐ Dry Eyes

List any EYE surgeries you have had in the past

_____ 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 Day
☐ 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:**

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SHADY GROVE OPHTHALMOLOGY™

9715 Medical Center Dr. Suite 502 Rockville, MD 20850
P (301)279-0600 F (301)294-5322

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 $75.00.**

HMO PLANS/REFERRALS: As the patient/guarantor, it is your responsibility to know your insurance benefits and to provide our office with accurate and current insurance information. If your specific insurance plan requires a referral to see a specialist, it is your responsibility to obtain the referral form from your primary care physician. If you arrive for an appointment without a referral on file, you have the option to reschedule the appointment or to pay in full for all services rendered on that day. If you do not have your referral on the day of your visit you will have 5 business days to obtain one from your primary care. Once we get the referral form, we will reimburse you for charges made on that service date.

CO-PAYMENTS: Will be collected at the time of service. There will be a $25 fee for returned checks.

MEDICARE: If you are a Medicare patient with a secondary insurance to your Medicare plan, it is your responsibility to provide both insurance identification cards. If the office does not have the proper information for a secondary insurance, the secondary will not be billed.

MEDICAL INSURANCE: It is your responsibility as the patient/guarantor to provide us with your current medical insurance card. If it has changed or not active on the day of your visit you may be asked to reschedule or become financially responsible for the balance in full. We do offer financing options through Care Credit.

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 financing options through Care Credit.

NO SHOW/LATE/CANCELLATION: If you are unable to keep your scheduled appointment, we ask that you give adequate notice (24 hours when possible, or prior to appointment time on the same day in an emergency) so that we may open your reserved time for another patient. We request that you keep scheduled appointments and arrive on time.
No-Show for your appointment will result in a $40 fee. If more than 15 minutes late, you may be asked to reschedule your appointment.

MVA AND OTHER FORMS: We will charge a $25.00 fee for MVA forms. Any other forms that require the doctor's signature and review will also be a $25.00 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. A copy of your valid driver's license will be required.

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.
Please be aware that we ask for at least 5 business days to release records.

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 this information, you will be held accountable for exam cost and reimbursed if and when information is obtained.

REFRACTIVE LENS EXHCHANGE, LASIK, PRK: This is a surgical procedure done after being evaluated and approved by the doctor. Appropriate to patients who want freedom from glasses and contacts. This is not covered by medical insurance. If you are unable to keep your surgical appointment, please let us know within 24 hours.

BILLING QUESTIONS AND PAYMENTS: Contact Carrie at our Billing Department for questions or concerns on bill related issues at (301) 762-0459.

I, _____(PRINT NAME) have read and understood Shady Grove Ophthalmology's policies and have discussed any questions to their staff.

_____ _____

Patient Signature Date

Modified 1/12/24

SHADY GROVE OPHTHALMOLOGY™

Anthony O. Roberts, MD
9715 Medical Center Dr, Suite 502
Rockville, MD 20850

P: (301)279-0600 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**

_____ **I have received a copy of the Patient Bill of Rights**

Date

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