Austin Pediatric Ophthalmology & Strabismus
New Patient Paperwork- Adult

Patient Name: First_____Last_____MI__ Date of Birth: _____ Gender: ____

Address: _____City: _____ Zip: _____

Cell Phone:( )_____ Home: ( )_____ Work: ( )_____

Driver's License #: _____ Marital Status: _____

Primary Insurance: _____ (Circle One) HMO PPO Indemnity Medicare Other

Identification #: _____ Group #: _____

Guarantor Name: First: _____MI: ___ Last: _____ DOB: _____

Guarantor's Address (if different from above): _____City: _____Zip: _____

Secondary Insurance: _____ (Circle One) HMO PPO Indemnity Medicare Other

Identification #: _____ Group #: _____

Guarantor Name: First: _____MI: ____ Last: _____DOB: _____

Guarantor's Address (if different from above): _____City: _____Zip: _____

Tertiary Insurance: _____

Identification #: _____ Group #: _____

Guarantor Name: First: _____MI: ____ Last: _____DOB: _____

List any member of your family that has previously been seen Dr. Busse or Dr. Thai: _____

_____

Name of Primary Care Physician: _____Phone: _____

Who can we thank for referring you to our office? (If different from PCP) _____

OFFICE POLICY AND PAYMENT AGREEMENT

All office visits are to be paid for at the time of your visit unless prior arrangements have been made. We do not file insurance on office visits unless we have a contract with your insurance company. We can, however, provide you with paperwork to submit an insurance claim yourself. Please feel free to discuss any of the charges or policies with our staff. We are glad to work with you in any way we can. It is your responsibility now and, in the future, to notify our office of any changes in your insurance company, identification number or plan changes.

I, _____ hereby agree to be financially responsible for fees incurred. I authorize the release of any medical information necessary to process the claim and request payment of insurance benefits, including Medicaid and other government sponsored programs to Dr. Megyn L. Busse, M.D. I hereby grant authority to Dr. Megyn L. Busse M.D. or any other provider employed by this practice, to perform an eye examination including tests necessary in the diagnosis and treatment of this patient.

Signature: _____Date: _____

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MEDICAL HISTORY

Name: _____ Date of Birth: _____

Name of referring doctor_____ Referring doctor phone# ( ) _____

Referring doctor address: _____City: _____ Zip: _____

Date of last eye exam _____

REVIEW OF SYSTEMS

Do you currently have any problems in the following areas?

If yes, please put explanation in space provided Below.

SKIN	YES	NO	
EYES			
Loss of Vision	YES____	NO____	_____
Double Vision	YES	NO	
Dryness	YES____	NO____	_____
Mucous discharge	YES	NO	
Redness	YES____	NO____	_____
Sandy or gritty feeling	YES	NO	
Itching	YES____	NO____	_____
burning	YES	NO	
Excess tearing/watering	YES____	NO____	_____
Occasional tearing	YES	NO	
Glare/Light sensitivity	YES____	NO____	_____
Flashes of light	YES	NO	
Floaters	YES____	NO____	_____
Eye pain or soreness	YES	NO	
EARS, NOSE, MOUTH, THROAT	YES____	NO____	_____
NECK	YES	NO	
RESPIRATORY(LUNGS/BREATHING)	YES____	NO____	_____
CARDIVASCULAR (HEART/BLOOD VESSELS)	YES	NO	
GASTROINTESTINAL (STOMACH/INTESTINES)	YES____	NO____	_____
BONES, JOINTS, AND MUSCLES	YES	NO	
NEUROLOGIC SYSTEM	YES____	NO____	_____
LYMPHATICS	YES	NO	
HEMATOLOGIC	YES____	NO____	_____
ALLERGIC/IMMUNOLOGIC	YES	NO	
PSYCHIATRIC	YES____	NO____	_____

OTHER _____

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PAST MEDICAL HISTORY

Please list current medications, hormones, oral contraceptives, vitamins you are presently taking:

1._____ 2._____ 3._____

4._____ 5._____ 6._____

7._____ 8._____ 9._____

10._____ 11._____ 12._____

Have you had crossed eyes, lazy eye, droopy eyelids, or protruding eye? _____

Do you have any allergies to any medication(s)? YES____ NO____ If YES, please list medications and reactions:_____

List all major illnesses and injuries:_____

List all previous surgeries:

FAMILY HISTORY (Please list personal history/family history)

			RELATIONSHIP TO PATIENT
Blindness	YES	NO	
Cataracts	YES	NO	
Glaucoma	YES	NO	
Macular degeneration	YES	NO	
Retinal detachment	YES	NO	
Strabismus	YES	NO	
Amblyopia	YES	NO	
Arthritis	YES	NO	
Cancer	YES	NO	
Diabetes	YES	NO	
Heart attack	YES	NO	
High blood pressure	YES	NO	
Kidney disease	YES	NO	
Stroke	YES	NO	

OTHER _____

SOCIAL HISTORY

Marital Status Single_____ Married_____ Separated_____ Divorced_____ Widowed_____ Other_____

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Current occupation _____

Do you currently wear glasses? _____

Do you drink alcohol? YES____ NO____ If YES, please indicate how many glasses per day _____

Do you smoke? YES____ NO____ If YES, how many packs per day _____

Important Patient Information

REFRACTION POLICY : 92015

What is a refraction exam?

This test is a determination of an eye's refractive error and the best corrective lenses to be prescribed. Doctors agree that this test is a necessary element of most visits, and it is used to create prescriptions for glasses and/or contact lenses, and/or to evaluate possible changes in vision due to medical conditions. This is essential to determine if a decrease in vision is due to only a need for glasses, which is easy to correct, or if another medical reason might be keeping the eye from seeing.

SENSORIMOTOR EXAMINATION: 92060

What is a sensory motor exam?

A sensory motor examination detects, assesses, monitors, and/or manages strabismic conditions. This is an expanded examination which requires additional time, effort, and expertise in measurement of the ocular deviation in various fields of gaze, different distances, and/or with and without optical correction. Doctors agree that information from the sensorimotor examination is used to plan medical, optical, and surgical treatments for these conditions and can have important visual, developmental, and/or systemic implications.

Does my insurance plan pay for this test/exam?

Your insurance may consider these procedures excluded from your benefits and/or a noncovered benefit.

What do you charge for these exams?

If your insurance does not cover the **92015** or **92060** the cost to you will be **$50.00 per test/exam performed.**

I have read and understand the above, and I have had the opportunity to ask questions.

_____

Patient Name

Date

_____ _____

I agree to have the following test/exam performed.

Date

_____ _____

I decline for the following test/exam to be performed and decline a glasses and/or contact prescription.

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Patient Financial Responsibility Agreement

•As a patient, it is in your best interest to know and understand your insurance plan benefits and your responsibility for any deductibles, co-insurance, or co-payment amounts prior to any, visit. Not all services are covered in all insurance contracts. In addition, you should be sure that your physician is listed as a participating provider by your insurance company. If your insurance plan does not cover a service or procedure, you are responsible for payment of these charges.

If your insurance is not valid, or your coverage was terminated at the time the services are rendered, you will be solely responsible for the full: amount of your office visit and/or any procedures rendered.

In addition, if your insurance plan determines a service or product to be "not covered, "you will be responsible for the complete charge of such services.

I agree to be responsible for the payment of ALL unpaid services rendered on my behalf, or my dependents.

_____ _____

Patient/Guardian Signature Date

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Meaningful Use Initiatives

At Austin Pediatric Ophthalmology we are required to implement the Meaningful Use Initiatives. As a result, we are collecting the government-mandated information below. The purpose of Meaningful Use is to improve patient care and lower health care costs. The information you provide will be used for reporting purposes only.

Patient Name_____ DOB:_____

Patient/Parent
Email:_____

Race:

- ❑ African American
- ❑ Asian
- ❑ Asian Indian
- ❑ Caucasian
- ❑ Other _____
- ❑ Refused to Report

Ethnicity:

- ❑ Hispanic
- ❑ Not Hispanic
- ❑ Refused to Report

Primary Language:

- ❑ English
- ❑ Spanish
- ❑ Other _____

Preferred Pharmacy:

Pharmacy Name: _____

Pharmacy Address: _____

Parent/Patient Signature_____ Date: _____

For Staff Use Only:

Data entered into ECW by: _____ Date:_____Scanned by: _____ Date:_____