LONG ISLAND & QUEENS
VITREO-RETINAL CONSULTANTS, P.C.

Date: _____

Last Name:_____ First Name:_____

Date of Birth:_____ Social Security #_____

Home Phone #:(____)_____ Cell Phone #:(____)_____

Email _____

(MR.___, MRS.____,MS.____,DR._____,) SEX: Male _____ Female _____

Marital Status: Single___ Married___ Widowed___ Divorced___ Other___

Mailing Address:_____

City:_____State:_____ Zip Code:_____

Street Address (if different from mailing address)_____

City:_____ State:_____ Zip Code:_____

Primary Language:

( ) English
( ) Spanish
( ) Other please list:
_____

Ethnicity:

( ) Hispanic origin
( ) Not of Hispanic origin
( ) Patient declined

Race:

( ) American Indian or Alaskan native
( ) Asian
( ) Black/African American
( ) Native Hawaiian or Pacific Islander
( ) White
( ) Patient declined

Emergency Contact Information

Name:_____ Relation:_____

Phone #:(____)_____ Alternate Phone #:(____)_____

PHARMACY INFORMATION:

Pharmacy_____

City _____State_____ Zip_____

Phone #:(___)_____Fax#:(___)_____

Doctor Information

Who Referred You To Our Practice?_____

Ophthalmologist / Optometrist Name:_____

Address:_____ **Phone #(____)**_____

City:_____ __**State:**_____ **Zip Code:**_____

Medical Doctor / Internist Name:_____

Address:_____ **Phone #:(____)**_____

City:_____ **State:**_____ **Zip Code:**_____

Insurance Information

Primary Insurance:_____ **Policyholder:**_____

Date of Birth:_____ **ID #:** _____

Relation to Patient:_____ **Employer/GRP#** _____

Secondary Insurance:_____ **Policyholder:**_____

Date of Birth:_____ **ID #:**_____

Relation to Patient:_____ **Policyholder:**_____

Employed: Yes___ No___ **Student: Yes___ No___**

Name of Employer / School:_____

Address:_____ **Phone #:(____)**_____

City:_____ **State:**_____**Zip Code:**_____

Responsible Party If Other Than Self: (Balances, Co-pays, Deductibles)

Name:_____ **Relation:**_____

Address:_____ **Phone #(____)**_____

IS YOUR VISIT *NO FAULT* OR *WORKER'S COMPENSATION* RELATED? YES NO
IF YES, PLEASE SEE RECEPTIONIST FOR ADDITIONAL PAPERWORK

Are you currently staying in a skilled nursing facility? YES NO

Name of Skilled Nursing Facility:_____

Address:_____**Phone#:**_____

NEW PATIENT MEDICAL HISTORY

Patient Name: _____ Date of Birth: _____ Date: _____

Are You currently in a: Rehab Facility, Skilled Nursing Facility, or Assisted Living: NO YES

What is the ocular reason for your visit today? (circle all that apply and describe if needed)

Blurred vision Distorted Vision Flashes & Floaters Shadow Double Vision Trauma Other:

Eye affected: Right Left Both

Severity: Mild Moderate Severe Describe:_____

Duration: _____ Days _____ Weeks _____ Months _____ Years

Associated symptoms: Eye pain Headache Light Sensitive

Location: Central vision Lower vision Upper vision Right Left Unable to localize

Quality: Sharp Tearing Dull ache Scratchy Hazy

Context Onset/Aggravation: After surgery On grid Reading Watching TV Driving

Duration of Episodes: Seconds Minutes Hours Constant

Modifying Factors: Artificial tears help Worse in am / pm Worse in bright light / dim

Recent Blood Sugar level:_____ Last Blood Sugar Test: Hemoglobin A1C: _____

Medications for the eyes and Eye Vitamins: (please indicate which eye and how often):

_____
_____
_____
_____
_____

Have you had the Flu Vaccine? NO YES Date: _____
Have you had the Pneumonia Vaccine? NO YES Date:_____
Have you fallen in the past year? NO YES Details:_____

What Past Medical Problems have you had. Please circle all that apply and describe if needed:

Cardiovascular:
Hypertension
High Cholesterol
Heart Attack Date:
Heart Surgery Date:
Pacemaker, Defibrillator Date:

Neurologic:
Stroke Date:
TIA Date:
Aneurysm
Parkinson's

Respiratory:
Asthma
COPD/Emphysema

Psychiatric:
Depression/Anxiety
Alzheimer

Infectious Disease:
HIV/AIDS
TB
Hepatitis

Musculoskeletal:
Arthritis
Joint Pain
Muscle Pain

Gastrointestinal:
Acid Reflux
Irritable Bowel Syndrome

Genitourinary:
Bladder Problems
Kidney Disease
On Dialysis: NO YES

Hematologic:
Anemia
Sickle Cell
Leukemia
Lymphoma
Cancer What type_____

Endocrine:
Diabetes Type 1 Years:_____
Diabetes Type 2 Years:_____
Liver Disease
Thyroid Disease

Were you premature at birth? NO YES
If yes, what was your birth weight?_____
If yes, how many weeks premature?_____

Please list ALL previous surgeries with dates:
_____
_____
_____

Are you currently taking Insulin? NO YES
Any Blood Thinners? (examples: Aspirin, Ecotrin, Coumadin, Warfarin, Plavix, Motrin, Advil)
NO YES If so, what type:_____

Medications (by Mouth, Injection, Spray, or Patch):

Medicine	Dose	Diagnosis

If Allergic to any of the following please circle:

Medicines? **Please give name of medicine and type of reaction:_____**

Dyes? **Fluorescein dye ICG Iodine or shellfish Latex**

Type of Reaction:_____

Other allergies? **_____**

Family History:			**Relationship to Patient:**
Blindness	**NO**	**YES**	**_____**
Cataract	**NO**	**YES**	**_____**
Glaucoma	**NO**	**YES**	**_____**
Macular Degeneration	**NO**	**YES**	**_____**
Retinal Detachment	**NO**	**YES**	**_____**
Diabetes	**NO**	**YES**	**_____**
Cancer	**NO**	**YES**	**_____**
Other	**NO**	**YES**	**_____**

Social History:

Drug use? **NO** **YES** **_____**

Smoke? **Never** **Former, but quit ____ years ago** **Current**

Alcohol? **None/rare** **<1 drink/day** **>1 Drink/day**

Marital Status: **Single** **Married** **Divorced** **Widowed**

Occupation: _____

Please circle and describe any current problems with:

Heart	**Endocrine (Pancreas, Thyroid)**	**Gastrointestinal**
Urinary	**Blood/Cancer (bleeding, wt loss)**	**Head, Throat**
Integumentary (skin)	**Musculoskeletal**	**Neurologic**
Breathing	**Other:**	

Do you wear glasses for distance vision? NO YES

SIGNATURE ON FILE

I request that payment of authorized benefits be made on my behalf to Long Island/Queens Vitreoretinal Consultants and/or its providers for services furnished to me. I authorize any holder of medical information about me to release to Empire Medicare Services or any other of my medical carriers any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of original.

1) SIGNATURE X _____Date:_____

PRIVACY POLICY I have been informed that LIVR/QVR has a privacy policy in place. I understand that this policy is posted in the office. I am aware that I may receive a copy of the policy at my request.

2) SIGNATURE X _____Date:_____

CONSENT TO RELEASE INFORMATION: **(PLEASE CIRCLE YES OR NO)**

1. I permit the practice to release my medical information to the physicians involved in my care. **YES NO**
2. I permit the practice to call my home or other designated location and leaving a message on voice mail or in person in reference to my care & treatment, appointment reminders, insurance items. **YES NO**
3. I permit the practice to mail to my home medical records, appointment reminders, patient statements. **YES NO**
4. I permit the practice to email information pertaining to my care, treatment, appointments, insurance items, patient statements and medical records. I have been informed that the email will be sent through an unencrypted format and I understand that there is a risk for a breach of confidentiality. **YES NO**
5. I permit the practice to text messages to my cell phone. **YES NO**

3) SIGNATURE: X _____Date:_____

I designate the following representative(s) who the provider can communicate with on my behalf **(example, friend, spouse, son, or daughter.)** If you do not designate anyone, the doctor will be unable to speak to anyone in your family regarding your medical condition.)

Name **Relationship**

Name **Relationship**

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY FOR USE OF NON-PARTICIPATING PROVIDERS

I hereby acknowledge & understand that under the terms of my insurance plan should I at any time & for whatever reason utilize the non-emergent services of any non-participating provider (including, but not limited to, doctor, laboratory, radiology & other ancillary services) I may not be covered in whole or in part of the associated costs and will bear the full financial responsibility for the costs of such services.

4) SIGNATURE: X _____Date:_____

LONG ISLAND VITREORETINAL CONSULTANTS, P.C.
QUEENS VITREORETINAL CONSULTANTS, P.C.

OUR FINANCIAL POLICY

Your clear understanding of our Financial Policies is important to our relationship.

COPAYS/BALANCES:

- Due at time of service
- Failure to pay copay at the time of service will incur a $10 service charge
- If a check is returned for insufficient funds, a $25 surcharge will be incurred
- Please do not ask us to waive copays as we cannot legally do so.

COINSURANCE/DEDUCTIBLES:

- Payment is expected promptly once your insurance plan informs our office that these expenses are patient responsibility.

REFERRALS:

- If your plan requires a referral from a primary care physician, it is your responsibility to obtain the written referral or authorization number prior to your visit with the doctor.
- YOUR APPOINTMENT WILL BE RESCHEDULED IF THE PROPER REFERRAL HAS NOT BEEN OBTAINED

MEDICARE PATIENTS:

- You are responsible for a yearly deductible and the 20% portion not paid by Medicare.
- If you have supplemental coverage we will submit the claims for you as a courtesy.
- If you are enrolled in a Medicare HMO plan (Oxford, Mediblue, etc.) it is your responsibility to inform our staff.
- We no longer accept tertiary insurance policies, however, we would be happy to provide you with the proper documentation that you can send for reimbursement

SELF PAY PATIENTS:

- PAYMENT IN FULL IS EXPECTED AT THE TIME OF SERVICE.

NO FAULT/WORKERS COMPENSATION PATIENTS:

- If the reason for your visit is due to a work related injury or because of an auto accident, you must inform the front desk upon check-in
- We reserve the right to obtain your regular health insurance information and/or a deposit prior to your visit, if the reason for your visit is not related to a work related injury or auto accident or if your claim is denied by your No Fault or Workers Compensation Insurance Carrier.

SURGERY/DRUG TREATMENT POLICY:

- ANY OUT OF POCKET EXPENSES (COINSURANCE, COPAYMENT OR DEDUCTIBLE) ARE EXPECTED TO BE PAID AT THE TIME OF SERVICE (for in-office procedures) OR WHEN YOUR SURGERY IS SCHEDULED (for hospital-based surgeries)

  **IMPORTANT: Any changes in your insurance company or plan must be stated at your time of visit, bring any new insurance cards to the office.

  If your insurance plan pays you directly, it is your responsibility to make payment to our offices immediately

Patient/Guardian Signature Date

(Nov 2013)