NAME_____

DATE_____

Date of birth _____

Who referred you to the office? _____

Who is your primary Doctor? _____

OCULAR HISTORY:
Have **you** ever been told you have:

Cataracts ***YES*** ***NO*** When? _____
Glaucoma ***YES*** ***NO*** How long? _____
Macular Degeneration ***YES*** ***NO*** How long? ____
Retinal Detachment ***YES*** ***NO*** When? _____
Other_____

Has anyone in your family (blood relatives) had any eye problems:

Cataracts ***YES*** ***NO***
Glaucoma ***YES*** ***NO***
Macular Degeneration ***YES*** ***NO***
Blindness ***YES*** ***NO***
Retinal Detachment ***YES*** ***NO***
Other_____

Medical history:
Have you ever been told you have:

Diabetes ***YES*** ***NO*** How long? _____
Hypertension ***YES*** ***NO*** How long? _____
Heart problems ***YES*** ***NO*** When? _____
Cholesterol ***YES*** ***NO***
Bleeding disorders ***YES*** ***NO***
Aids or HIV ***YES*** ***NO***

Has anyone in your family (blood relatives) had any Of these conditions:
Diabetes ***YES*** ***NO***
Who? _____
Hypertension ***YES*** ***NO***
Who?

Please list:
Your eye medications:

_____
_____
_____
_____

List any other medications given to to you by your family Dr. including Aspirin:

_____
_____
_____
_____

Major medical conditions:
Cancer _____
Heart attack _____
Thyroid problems _____
Breathing or lung problems
_____
Other _____
_____
_____

Allergic to medications
Iodine ***YES*** ***NO***
Penicillin ***YES*** ***NO***
Sulfa ***YES*** ***NO***
Others _____
_____
_____

Social history:
Do you smoke? ***YES*** ***NO***
how much? _____
Drink alcohol ***YES*** ***NO***
how much? _____

Occupation _____

CONTINUE >>

HAVE YOU HAD OR ARE YOU HAVING ANY OF THESE SYMPTOMS CURRENTLY?

REVIEW OF SYSTEMS

CONSTITUTIONAL SYSTEMS YES NO
Fever ..... ___ / ___
Weight loss..... ___ / ___
Other _____

EYES YES NO
Blurry vision..... ___ / ___
Burning..... ___ / ___
Do you have difficulty reading small print? ..... ___ / ___
Other _____

EARS, NOSE, MOUTH, THROAT YES NO
Sinus Congestion..... ___ / ___
Dry throat—mouth..... ___ / ___
Other _____

CARDIOVASCULAR YES NO
Congestive heart failure..... ___ / ___
Heart attacks..... ___ / ___
Irregular—fast heartbeat..... ___ / ___
High Blood pressure..... ___ / ___
Other _____

RESPIRATORY YES NO
Asthma..... ___ / ___
Emphysema..... ___ / ___
Other _____

GASTROINTESTINAL YES NO
Jaundice—hepatitis..... ___ / ___
Cancer..... ___ / ___
Other _____

GENITOURINARY YES NO
Kidney disease..... ___ / ___
Other _____

INTEGUMENTARY (skin and/or breast) YES NO
Skin disease..... ___ / ___
Breast cancer..... ___ / ___
Other _____

MUSCULO—SKELETAL YES NO
Rheumatoid arthritis..... ___ / ___
Lupus..... ___ / ___
Other _____

NEUROLOGICAL YES NO
Dizziness..... ___ / ___
Migraines..... ___ / ___
Other _____

PSYCHIATRIC YES NO
Depression..... ___ / ___
Schizophrenia..... ___ / ___
Other _____

HEMATOLOGICAL/LYMPHATIC YES NO
Anemia..... ___ / ___
Bleeding disorder..... ___ / ___
Other _____

ALLERGIC/IMMUNOLOGIC YES NO
Head allergy symptoms..... ___ / ___
Seasonal allergies..... ___ / ___
Other _____

ENDOCRINE YES NO
Diabetes..... ___ / ___
Cancer-pancreas/adrenal glands..... ___ / ___
Thyroid problems..... ___ / ___
Other _____

DATE-_____

NAME -_____ MALE FEMALE

BIRTH DATE____-____-_____AGE_____SOCIAL SECURITY#_____

ADDRESS _____

STREET CITY STATE ZIP CODE

HOME PHONE ( ) _____-_____ SINGLE MARRIED WIDOWED

CELL PHONE ( ) _____-_____

EMPLOYER NAME _____

EMPLOYER PHONE # ( ) _____-_____

NAME OF PARENT IF MINOR _____

NEAREST RELATIVE _____

PHONE #

FAMILY PHYSICIAN _____

NAME ADDRESS PHONE #

REFERRED BY _____

ADDRESS _____

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS CLAIMS AND AUTHORIZE PAYMENT OF BENEFITS TO THE PROVIDER MENTIONED BELOW. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY UNPAID BALANCE ON MY ACCOUNT IF THE INSURANCE REJECTS.

PATIENT SIGNATURE _____***DATE***_____/_____/_____

INSURANCE NAME _____

INSURANCE ADDRESS_____

SOCIAL SECURITY # OF SUBSCRIBER_____-_____-_____

DATE OF BIRTH FOR PRIMARY CARD HOLDER
(EXAMPLE) HUSBAND WIFE OR PARENT _____/_____/_____

DUE TO HIPPA REGULATIONS

HIPPA Toolkit Form E
Notice and Acknowledgement

Acknowledgement:

I acknowledge that I received the attachment Notice of the Privacy Practices.

_____ Date_____
Patient or Personal Representative Signature

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient: _____

Information can be released to: _____

Supplier, Provider or Group
"One time authorization "
Statement to permit payment of Medicare benefits to Providers, Physicians and Patients

Dr. Alan W. Solway, M.D
Dr. Christopher R. Papp, M.D. _____
Name of Physician

_____ Payment to Patient ____X____Payment to Provider

Patient Signature: _____ Date_____

Provider Signature: _____ Date_____

Provider Name: Alan W. Solway M.D., Dr. Christopher R. Papp, M.D.

For services furnished to inpatient of a hospital or SNF, this request is effective for the period of confinement. For services furnished by a provider or on an outpatient basis, this request is effective until revoked by the beneficiary.

For durable medical equipment- this procedure is limited to assigned claims, because of the danger or incorrect payment that could otherwise result if the patient dies, recovers or goes into an institution and must be renewed if a new item is rented or purchased. The supplier assumes unconditional responsibility for funding any payments that may result because the carrier did not receive prompt notice that DME had been returned or is no longer needed or the enrollee has died or been institutionalized.

Note: This statement must be maintained for each patient individually.