ELDORADO RETINA ASSOCIATES, P.C.

Mary B. Lansing, M.D.
90 Health Park Drive, Suite 100 • Louisville, CO 80027
Phone (303) 666-1800 • Fax (303) 666-8830

PATIENT DEMOGRAPHICS

Dear patient - Please help us provide you with the best possible care by completing the following information as completely as possible.

PATIENT INFORMATION

Today's Date: ___________________

Patient's Legal Name:

Last Name _______________ First Name _______________ Middle Initial _______ Nickname _______

Date of Birth:_____________________ SSN:___________________________ Sex: ☐ Male ☐ Female

Mailing Address _______________ City _______________ State _______ Zip Code _______

Home Phone:_____________________ Cell Phone:_____________________ Work:_________________________
Can we leave a message? Yes / No Can we leave a message? Yes / No Can we leave a message? Yes / No

Preferred Phone Number (please check one): ☐ **Home** ☐ **Cell** ☐ **Work**

Occupation:_____________________________________ ☐ Full-time ☐ Part-time ☐ Retired ☐ Not employed

E-Mail Address: ____

How did you hear about Dr. Lansing? ☐ Eye doctor ☐ Other doctor ☐ Online ☐ Patient ☐ Other:_____________

Name of referring physician:_______________________________________ Phone:_________________________

Name of primary care physician:___________________________________ Phone:_________________________

PHARMACY INFORMATION

Name of Pharmacy:____ Phone:_________________________

Location:____ Fax:___________________________

IDENTIFYING INFORMATION

Preferred Language:_____________________________

Ethnicity (please check one):
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Unknown
☐ Declined to specify

Race (please check one):
☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ White
☐ Other Race
☐ Declined to specify

IN CASE OF EMERGENCY

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐ Partner ☐ Unknown

Name of spouse/significant other:_______________________________________ Phone:_________________________

In case of emergency, who can we contact? *(Someone that you do not live with)*

Name:____ Relationship:__________________________________

Phone 1:_______________________________________ Phone 2:______________________________________

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PATIENT HEALTH QUESTIONNAIRE

Dear Patient - Please help us provide you with the best possible care by completing the following information as completely as possible.

PATIENT INFORMATION

Patient's name:____ **Today's date:**____________

PHYSICIAN INFORMATION

Family doctor's name:____________________________________ Phone: ________________________

Name of ophthalmologist/optometrist:________________________ Phone: ________________________

Other doctor's (endocrinologist, cardiologist, etc.): ____

____

ALLERGIES

Do you have any serious **ALLERGIES** to any medications? ☐ Yes ☐ No

If yes, please list medications: ____

____

Do you have any **ALLERGIES** to latex or adhesives? ☐ Yes ☐ No

What is the reason for your visit today? (check all that apply)

☐ Blind spot	☐ Difficulty with reading	☐ Flashes of light	☐ Macular evaluation
☐ Blurred Vision	☐ Distorted vision	☐ Floaters (seeing "spots")	☐ Retinal evaluation
☐ Comprehensive eye exam	☐ Double vision	☐ Loss of peripheral vision	☐ Other:__________.
☐ Diabetic evaluation	☐ Eye pain	☐ Loss of vision	☐ Unknown

INJURY RELATED?

Were you referred because of an eye injury? ☐ Yes ☐ No If so, what is the date of the injury? ____________

Please describe the injury: ____

SOCIAL HISTORY

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐ Partner ☐ Unknown

Do you drive a car?	☐ Yes	☐ No	Drive with restrictions: ☐ Locally ☐ Daytime only
Do you *currently* use tobacco products?	☐ Yes	☐ No	If yes, how much? _____________________
Have you previously used tobacco products?	☐ Yes	☐ No	When did you quit? How much? __________
Do you drink alcohol?	☐ Yes	☐ No	If yes, how much? _____________________

SOCIAL HISTORY (continued)

Do you use recreational drugs? ☐ Yes ☐ No If yes, describe: ________________________

Occupation:___________________________________ ☐ Full-time ☐ Part-time ☐ Retired ☐ Not employed

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, in what year? ____________________

Have you ever had a sexually transmitted disease? ☐ Yes ☐ No If yes, which type? ______________________

MEDICAL HISTORY			***OCULAR HISTORY***		
SELF		**FAMILY**	SELF		**FAMILY**
Yes / No	High Blood Pressure (year dx: ________)	Yes / No	Yes / No	Cataracts	Yes / No
Yes / No	Heart Disease (year diagnosed: _______)	Yes / No	Yes / No	Glaucoma	Yes / No
Yes / No	Diabetes (year diagnosed: ___________)	Yes / No	Yes / No	Strabismus / Eye Turn	Yes / No
Yes / No	Cancer (type: _____________________)	Yes / No	Yes / No	Amblyopia / Lazy Eye	Yes / No
Yes / No	Arthritis (type: _____________________)	Yes / No	Yes / No	Retinal Detachment	Yes / No
Yes / No	Respiratory Disease / Asthma	Yes / No	Yes / No	Eye Injuries (date: _____________)	Yes / No
Yes / No	Circulation Problems / Stroke	Yes / No	Yes / No	Diabetic Retinopathy	Yes / No
Yes / No	Multiple Sclerosis (year diagnosed: _____)	Yes / No	Yes / No	Macular Degeneration	Yes / No
Yes / No	HIV+ (year diagnosed: ______________)	Yes / No	Yes / No	Eye Surgery (type: ______date: ____)	Yes / No
Yes / No	Hepatitis (type: __________________)	Yes / No	Do you have any other ocular diagnoses? please explain: _____ ____		
Yes / No	Allergies (seasonal / hay fever)	Yes / No			
Family history is unknown / patient is adopted		Yes / No			

CHRONIC MEDICAL CONDITIONS

Please list any other **chronic medical conditions** that you have (i.e. thyroid disease, Crohn's, Parkinson's, dementia, etc.): ____

____

____

Please list all ***MEDICATIONS***, ***VITAMINS***, *and* ***SUPPLEMENTS*** that you are currently taking:		***SURGICAL HISTORY*** (please list ***ALL*** surgeries you have had)	
NAME OF MEDICATION	DOSAGE	NAME / TYPE OF SURGERY	YEAR(S)

Please check **any** item that applies to your ***CURRENT HEALTH***:

Cardiovascular:
☐ Negative
☐ Chest pain
☐ Shortness of breath
☐ Swelling of the feet
☐ Shortness of breath when laying flat
☐ Racing pulse
☐ Irregular heartbeat
☐ Blood pressure stable per patient
☐ Blood pressure uncontrolled
☐ Unsure if blood pressure control
☐ No shortness of breath
☐ No chest pain
☐ No chest pain or shortness of breath
☐ Unspecified

Constitutional:
☐ Negative
☐ Fever
☐ Weight loss
☐ Fatigue
☐ Loss of appetite
☐ Chills
☐ Unexplained weight loss
☐ Night sweats
☐ Feels sick
☐ Poor appetite
☐ No fevers, fatigue, or weight loss
☐ Unspecified

Endocrine:
☐ Negative
☐ Excess thirst
☐ Excessive urination
☐ Heat intolerance
☐ Cold intolerance
☐ Hair loss
☐ Dry skin
☐ Blood sugars poorly controlled
☐ Blood sugars stable per patient
☐ Unsure of glycemic control
☐ Unspecified

Gastrointestinal:
☐ Negative
☐ Abdominal pain
☐ Nausea
☐ Diarrhea
☐ Bloody stools
☐ Stomach ulcers
☐ Constipation
☐ Trouble swallowing
☐ Gastrointestinal ulcers
☐ Jaundice or yellow skin
☐ Unspecified

Genitourinary:
☐ Negative
☐ Pain/burning on urination
☐ Blood in urine
☐ Bladder trouble
☐ Dialysis
☐ Genital sores or ulcers
☐ Kidney failure
☐ Kidney problems
☐ Kidney stones
☐ Prostatitis
☐ Testicular pain
☐ Urinary discharge
☐ Unspecified

Hematology/Oncology:
☐ Negative
☐ Easy Bruising
☐ Prolonged bleeding
☐ Unspecified

HENT:
☐ Negative
☐ Hearing loss
☐ Sore throat
☐ Runny nose
☐ Dry mouth
☐ Jaw claudication
☐ Ear ache
☐ Unspecified

Integumentary:
☐ Negative
☐ Rash
☐ Change in mole
☐ Rashes skin sores
☐ Skin cancer
☐ Severe itching
☐ Loss of hair
☐ Unspecified

Musculoskeletal:
☐ Negative
☐ Muscle aches
☐ Joint pain
☐ Difficult laying flat due to musculoskeletal discomfort
☐ Back pain while sleeping or awakening
☐ Unspecified

Neurologic:
☐ Negative
☐ Weakness
☐ Headaches
☐ Scalp tenderness
☐ Dizziness
☐ Paralysis of extremities
☐ Tremor
☐ Stroke
☐ Numbness
☐ Numbness or tingling
☐ Seizures or convulsions
☐ Fainting
☐ Unspecified

Respiratory:
☐ Negative
☐ Wheezing
☐ Cough
☐ Coughing up blood
☐ Severe or frequent colds
☐ Difficulty breathing
☐ No cough or wheezing
☐ Unspecified

Psychiatric:
☐ Memory loss
☐ Confusion
☐ Depression

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FINANCIAL POLICY STATEMENT

Dear Patient, Thank you for choosing Eldorado Retina Associates as your health care provider. We are committed to providing the best possible service and treatment to make your visit a success. Please understand that payment of your bill enables us to maintain our standard of care. The following is a statement of our Financial Policy, which we request that you read and sign prior to any treatment.

If you would like to submit charges directly to your insurance company, we will provide you with the necessary documentation. Payment for your services will be due at the time of your visit.

Medicare

We participate with Medicare and accept assignment. As a courtesy to you, we will bill your secondary insurance company provided you supply us with that information. You are responsible for any deductible, co-insurance, and non-covered services.

Commercial Insurance Companies

As a courtesy to you, we will submit claims to any commercial insurance company provided we have the company's name and complete mailing address. If payment is not received from your insurance company within 60 days, the balance will become your responsibility.

HMO/PPO Insurance

We participate with various HMO/PPO insurance companies. If you need clarification as to whether we participate with your HMO/PPO please ask the office. It is your responsibility to obtain all referrals and authorizations for office visits prior to your appointment. It is also your responsibility to pay any co-payment that you have agreed upon with your HMO/PPO at the time of your visit.

Patients without insurance Coverage

If coverage by an insurance company is not active for the date of service, you are required to pay at the time the services are rendered.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

YOUR RESPONSIBILITY FOR PAYMENT

In the event that your insurance company sends payment for services directly to you, it is your responsibility to forward the payment along with a copy of the explanation of benefits to our office. If there is a remaining balance after payment has been received from your insurance company, the payment of this balance is your responsibility. If you are not covered by insurance, all charges are your responsibility.

RELEASES

I hereby authorize Eldorado Retina Associates, P.C. to release any information requested by my insurance company, admitting hospital and/or referring physicians, on behalf of me or my family. I hereby authorize Eldorado Retina Associates, P.C. to make complaints to the State Insurance Commissioner, the Health Care Financing Administration, or the Department of Labor on my behalf regarding my benefits

I have read the Financial Policy. I understand and agree to this Financial Policy.

_______________________________ _______________

SIGNATURE OF RESPONSIBLE PARTY DATE

_______________________________ _______________

SIGNATURE OF CO-RESPONSIBLE PARTY DATE

PLEASE READ AND SIGN THE APPROPRIATE SECTION BELOW:

Patient's Insurance Authorization (Non-Medicare)

I hereby authorize the processing of the medical insurance either by electronic or manual method by Eldorado Retina Associates, P.C. My signature below authorizes payment of all major medical and/or surgical benefits to which I am entitled from my insurance company(s) to pay to Eldorado Retina Associates, P.C. I further authorize assignee to release all medical and/or insurance claim information necessary to secure the payment(s). I recognize my financial obligation of any co-insurance or deductible, and non-covered services that may be required. This agreement will remain in effect until revoked by me in writing. A photocopy of this document is to be considered as valid as an original.

_______________________________ _______________

SIGNATURE OF PATIENT DATE

Patient's Authorization (Medicare)

I request that payment of authorized Medicare benefits be made on my behalf to Eldorado Retina Associates, P.C. for any services furnished to me by Eldorado Retina Associates, P.C. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature below requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance coverage is indicated in Item 9 of the HCFA-1500 claim form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to that insurer or agency. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

_______________________________ _______________

SIGNATURE OF PATIENT DATE

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GUARANTEE OF PAYMENT CONSENT FORM

Patient Name: ____

I understand that my insurance will be billed for each visit and then I will be billed by Eldorado Retina Associates, P.C. for any deductible or coinsurance due. I have 30 days to pay.

I AUTHORIZE ELDORADO RETINA ASSOCIATES, P.C. to charge my payment card for the balance due if I have ***NOT PAID OR CONTACTED*** Eldorado Retina Associates, P.C. for payment arrangements.

______________________________	____________________
Card Holder Name (please print)	Relationship to patient

____
Card Holder Signature

______________________________	____________________
Card Number	Expiration Date

Card Type:

- □ Visa
- □ MasterCard

(Unfortunately, we no do not accept American Express or Discover card)