

Dana Tannenbaum, M.D.
PATIENT INFORMATION SHEET
(Please Print)

Referred by: _____

Today's date: _____

Home Telephone: _____

PATIENT INFORMATION

Mr. Mrs. Ms. _____ Social Security #: _____

Address: _____ City: _____ ST: _____ ZIP: _____

Date of Birth: _____ Age: _____ Sex: M F Race: _____ Cell Phone: _____

E-Mail Address: _____

Marital Status: Single / Married / Divorced / Separated / Widowed Name of Spouse: _____

Patient Employed By: _____ Patient Occupation: _____

Employer Address: _____ Phone: _____

MEDICAL DOCTOR INFORMATION

Medical Doctor: _____ Phone: _____

Medical Doctor's Address: _____

IN CASE OF EMERGENCY

Name (not living at same address): _____ Relationship to patient: _____

Home Telephone: _____ Work Telephone: _____

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Is Medicare your primary insurance: Yes No Medicare # _____

Payment information for first visit: Check Cash Credit Card Insurance

PRIMARY Insurance company name: _____ ID# _____

Mailing Address: _____ Group# _____

Name of Insured: _____ Relationship to Patient: _____

Date of Birth of Insured: _____

SECONDARY Insurance company name: _____ ID# _____

Mailing Address: _____ Group# _____

CONDITIONS

(Check any of the following if you currently have, or have had in the past.)

	Date/Duration		Date/Duration
_____ Blurred Vision	_____	_____ Headaches	_____
_____ Cataracts	_____	_____ Loss of Vision	_____
_____ Crossed Eyes	_____	_____ Retinal Disease	_____
_____ Double Vision	_____	_____ Seeing Flashes	_____
_____ Eye Infection	_____	_____ Seeing Halos	_____
_____ Eye Injury	_____	_____ Sensitivity to Light	_____
_____ Eye Surgery	_____	_____ Wear Contact Lenses	_____
_____ Floaters	_____	_____ Type of Lens:	_____
_____ Glaucoma	_____	_____ Hours per Day:	_____

MEDICATIONS

Please list all

ALLERGIES

Please list all

HEALTH HISTORY

Please check the appropriate line "yes" or "no" to indicate if you have had any of the following. Also place a mark to indicate if a blood relative has had any of the following problems.

	Yourself		Family Member			Yourself		Family Member	
AIDS/HIV	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis (Type _____)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Artificial Heart Valve	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Lupus	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Migraine Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bleeding	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Shingles	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Skin Conditions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Drug Sensitivity	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thyroid Conditions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hay Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are you pregnant? _____	# of Children _____			
Heart Condition	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tobacco Use _____	Alcohol Use _____			

FINANCIAL ASSIGNMENT AND AGREEMENT

Our practice is committed to providing you with the highest quality of patient care. The following statement of our financial policy which we require that you read and sign prior to any treatment being rendered. (Note: All patients must complete our "Patient Information Form" prior to seeing any physician in the practice.)

Cash Patients:

If you do not have a valid insurance plan to cover the costs of our services you will need to make full payment at the time of service. We accept cash, checks, or credit cards. Other payment arrangements may be arranged with the practice administrator prior to treatment.

Medicare Patients:

Please remember that your deductible must be met for each calendar year.

Private Insurance/Third Party Injury Patients:

We will bill your insurance as a courtesy to you. We do, however, require full payment at the time of your service unless prior arrangements have been made. (Note: Your insurance policy is a contract between you and the insurance company. We are not a party to that contract. Therefore, you are completely responsible for the cost of your treatment.)

HMO/PPO Patients:

You are responsible for your contracted portion of reimbursement or co-payment at the time of service. If your co-payment is not made at the time of service, an additional fee may be charged for administrative costs.

Missed Appointments:

Due to our efforts to accommodate all patients when they need to be seen, we ask that if you are unable to keep your scheduled appointment, that you cancel no later than 24 hours in advance. We understand that although circumstances at times may prevent doing this, after a second missed appointment we may add a \$25.00 missed appointment charge to your account.

Minor Patients:

Written or verbal parental consent is required by law if the minor is not accompanied by a parent. For families with dual insurance coverage, a birthday law applies. The birth date (birth month) of the parent that falls first in the year becomes primary.

Other Fees:

In the event that you need copies of your medical records, a copy fee will be charged, \$0.10 per page.

Third party exams that require additional forms to be completed by the physician or staff may be subject to a \$25.00 form fee.

We accept cash, checks, Visa, MasterCard, and Discover.

SIGNATURE OF ACKNOWLEDGMENT:

I realize that I am responsible for payment of all medical services rendered to me and/or my dependents, regardless of the decision of reimbursement made by my insurance carrier.

I have read the above and acknowledge that I am aware of the practice's Financial Policy.

I authorize payment from my insurance carrier(s) for medical and/or surgical benefits to the treating physician.

I further authorize my physician to release any and all information necessary concerning my diagnosis and treatment for the purpose of securing payment from my insurance carrier(s).

NOTE: Your signature below will remain in effect unless written consent is received to revoke your authorization.

Signed (Patient or Parent if minor) _____ **Date** _____

PROTECTED HEALTH INFORMATION RELEASE

I, _____, hereby authorize the release of my medical information to: _____
(State relationship to patient and full name of party/parties authorized to receive medical information.)

By signing this form, you authorize the Practice to use and disclose protected health information about you for reasons you have been made aware of. You have the right to revoke this authorization at any time, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior authorization. Should you want to revoke disclosure of any information in your chart, please submit in writing.

Signed _____ **Date:** _____

Witness: _____ **Date:** _____