SWITCH EYE CENTER PATIENT INFORMATION SHEETS

Today's Date: _____/_____/_____ **Age:** _____

Name: _____
Last First Initial

Address: _____
Street Apt.#

_____
City State Zip Code

Home Phone#(_____) _____ **Business and/or Cell** (_____) _____

Date of Birth ____/____/____ **Social Security#** _____-_____-_____

Email_____ **Preferred Language**_____

Marital Status [] Single [] Married [] Divorced [] Widowed **Sex** [] Male [] Female

Employer: _____
Company Name Street City State Zip Phone

Spouse/Parent: _____
Last First Date of Birth

Emergency Contact Person: _____
Name/Relationship Phone#

Primary Care Physician: _____
Name Phone#

Pharmacy Name: _____/_____/_____/_____
City Cross Street Phone#

How did you hear about us? Friend/ Family Doctor Referral Commercial Website

If commercial, what channel:_____

Insurance Information (We only bill medically, we do not bill any vision insurance. Dr. Switch is a specialist)

Primary Insurance: _____ Subscriber: _____ DOB _____/_____/_____

Secondary Insurance: _____ Subscriber: _____ DOB _____/_____/_____

I authorize the release of any medical information needed to process all claims and I authorize the release of payment for medical benefits to my physician.

Patient or Parent Signature: _____ Date: _____

Review of Systems

If you have any of the following medical conditions, please circle the appropriate reply.
If yes, please describe:

Y N **Y N**

[] [] High/Low Blood Pressure [] [] Breathing Problem Type:_____

[] [] Cholesterol [] [] Heart

[] [] Thyroid [] [] Diabetes Type:_____ Years:_____

[] [] Arthritis [] [] Psychiatric Issue _____

[] [] Auto Immune Disease (example MS) Type:_____

Major Surgery **(Body and/or Eyes):** _____

_____

Family History (Please list medical condition and relationship)

[] Cataracts_____ [] Glaucoma _____

[] Macular Degeneration_____ [] Retinal Detachments_____

[] Diabetes_____

Social History

Y N

[] [] Alcohol How much/ often? _____

[] [] Tobacco How Much? _____ How Long/ years? _____

Allergies to Medication [] Yes [] No (If yes, please list the medication(s) below)

_____

Medication [] Yes [] No (If yes, please list all current medications. Please include any eye drops)

_____ ____mg ____times daily _____ ____mg ____times daily

_____ ____mg ____times daily _____ ____mg ____times daily

_____ ____mg ____times daily _____ ____mg ____times daily

OFFICE FINANCIAL POLICY

1. There will be a charge for all services performed by the doctor in the office and/or the hospital. By allowing the doctor to care for you, you agree to pay for the services rendered. If you have an insurance with which we do not participate, you are expected to pay for your care at the time of your visit. **WE ACCEPT CASH, CHECK, VISA, MASTER CARD, AMERICAN EXPRESS, AND CARE CREDIT**. There will be an NFS fee on all returned check, and cash payments will be required for all future transactions. Any procedures, which are performed, will be billed to your insurance company. If there are any co-payments or deductibles, your portion is due at the time of the service. If the procedure is not covered by your insurance, you will be responsible for the entire fee. If you do not make full payment within 30 days of your first billing statement, an additional $5.00 fee will be applied to your current balance, for every statement mailed.

2. **SURGERY**: If there are any co-payments or deductibles for surgeries to be performed, we may require payment prior to the date of surgery.

3. **MASTER MEDICAL POLICY**: All Master Medical patients are required to pay services in full on the service date. As a courtesy, we will file your Master Medical Claim, and the insurance company will reimburse you directly.
4. We reserve the right to charge a $10.00 dollar fee for all disability and financial forms or patient records, etc., that are requested by the patient.

5. If payment is received by the office, for services that have been paid in full, a credit balance will be applied to your account or refund may be issued.

6. **REFERRALS:** Some insurance companies require written referral authorizations from your primary care physician (i.e., AETNA/HAP/BLUE CARE NETWORK/HMO). It is YOUR responsibility to make sure the proper referral has been received or brought with you on the day of your appointment. If you do not have your referral the day of your appointment, you may be asked to reschedule your appointment.

PATIENT SIGNATURE_____ DATE_____