Dr Martin Reinke

Board Certified Ophthalmologist

PATIENT INFORMATION FORM

Please print and provide complete information .

First Name_____MI_____Last Name_____

Address_____City_____State_____Zip_____

Home Phone_____Cell_____Other_____

Date of Birth_____Age_____Sex_____

Email:_____SSN:_____

Marital Status:(circle) S M W D - Spouse Name_____Phone_____

Race: ○ African American ○ Asian Pacific ○ Caucasian

○ Hispanic ○ Native American ○ Other:_____

○ Decline to specify

Are you currently employed? Y N Retired? Y N

EMPLOYER_____Address_____

City_____State_____Zip_____Phone_____

Occupation_____

Emergency Contact_____

Relationship to patient_____Phone_____

Please tell us how you found out about us:(circle)

Physician/Friend/Insurance/Company/Other_____

Referred by_____ OD MD DO Phone_____

PLEASE READ AND SIGN BELOW

I authorize Dr Martin Reinke and staff of MHR Eye Association to perform procedures necessary to assess and diagnose my condition properly and to perform treatments as may be prescribed by Dr Reinke during any and all visits to MHR Eye Association. I understand that I am financially responsible for ALL charges for services rendered to me by MHR Eye Association.

Signature_____Date:_____

Dr Martin Reinke
Board Certified Ophthalmologist

Patient History Questionnaire Page 1

Name: **Date:**

Allergies and Drug Reactions:

Medications: (please list all current medications, including over the counter vitamins, etc.)

○ I am not on any prescription medications.

○ I am on blood thinner or aspirin.

1)_____ 2)_____
3)_____ 4)_____
5)_____ 6)_____
7)_____ 8)_____
9)_____ 10)_____

○ I have attached my medication list on a separate form.

Review of Systems: If you are <u>currently</u> having any problems in the following areas, please circle below.

Allergy/Immunology: environmental allergies, food allergies, other:_____

Cardiovascular: chest pressure, discomfort, irregular heartbeat, other:_____

Constitutional: fatigue, fever, night sweats, other:_____

Endocrine: cold intolerance, heat intolerance, other:_____

Ear, Nose, Throat: hearing loss, sinus problems, hoarseness, other:_____

Gastrointestinal: constipation, diarrhea, vomiting, other:_____

Genitourinary: frequent urination, incontinence, back pain, other:_____

Blood/Lymph Nodes: bruising, easy bleeding, swelling, other:_____

Skin(Integumentary): rash, skin lesion, infection, other:_____

Musculoskeletal: joint swelling, muscle weakness, stiffness, other:_____

Neurological: dizziness, tremors, headache, other:_____

Psychiatric: mood swings, anxiety, depression, other:_____

Respiratory: couch, wheezing, snoring, other:_____

Name: _____

Date of Birth:_____Age:_____Weight:_____Height_____Sex: M F

Reason for todays visit:_____

Do you wear ◯ Glasses ◯ Contacts

Ocular Medical History: (Please list all Eye diseases or eye surgeries you have had)

_____ _____

_____ _____

_____ _____

Have you ever been diagnosed with: ◯ Cataracts ◯ Retina problems ◯ Glaucoma

Medical History: Please check the following if they apply to yourself:

◯ Anemia ◯ Arthritis ◯ Asthma

◯ Cancer: When_____type_____ Chemo: Y N Radiation: Y N

◯ Chest pain ◯ COPD

◯ Diabetes: Type 1 Type 2 Year Diagnosed_____ Do you take insulin Y N

◯ Emphysema ◯ Heart Attack: Year_____ ◯ Congestive Heart Failure

◯ Heart Murmur ◯ Hepatitis Type_____ ◯ High Blood Pressure

◯ High Cholesterol ◯ Kidney/Bladder Disease ◯ Liver Disease

◯ Pacemaker ◯ Prostate: Have you ever taken Flomax? Y N

◯ Seizures ◯ Stroke/TIA Year_____ ◯ Thyroid Disease

◯ Ulcer ◯ Vascular DVT/Pulmonary Embolism

◯ **History of Head or Eye Trauma** (please describe)_____

◯ Any other health conditions not listed above:_____

Previous Injuries, Surgeries, Treatments, Hospitalizations and other Medical Problems:

_____ _____

_____ _____

_____ _____

_____ _____

Family History: Please specify family relationship if they apply, example: mother, father, etc.

Blindness:_____Heart Disease:_____Glaucoma:_____

Lupus:_____Diabetes:_____Stroke:_____

Macular Degeneration:_____Thyroid Disease:_____

Cancer: Type:_____Other:_____

Social History:

Do you drink alcohol? ◯ Yes ◯ No Drinks per week?_____

Do you smoke? ◯ Yes ◯ No PPD_____Years_____

Previous smoker? ◯ Yes ◯ No When did you quit?_____Years smoked_____

Signature:_____**Date:**_____

INSURANCE INFORMATION

Please print and provide complete information.

There is no guarantee that your insurance company will pay for all services rendered. Any medical services not covered by an individual's insurance plan are the patient's responsibility and payment in full is due at the time of visit. If we have not received payment from your insurance company within sixty days(60) we will notify you and unpaid balances will become your responsibility, and we will expect payment in full at that time. It is the patient's responsibility to pay any deductible or any portion of the charges specified by the plan at the time of each visit. Our office does not bill patients for any copays, deductibles or coinsurance.

We are happy to help with insurance questions relating to how a claim was filed, however, specific coverage issues, can only be addressed by the insurance company's member services department (the member services number is listed on the back of your insurance card).

Our practice firmly believes that a good doctor/patient relationship is based upon understanding and good communication. Please do not hesitate to contact us. We are here to help you!

PLEASE NOTE: IT IS THE PATIENTS RESPONSIBILITY TO ENSURE THAT ANY REQUIRED REFERRALS FOR TREATMENT ARE OBTAINED BEFORE THE VISIT OR THE PATIENT MAY BE FINANCIALLY RESPONSIBLE DUE TO THE LACK OF THE REFERRAL AT THE TIME OF SERVICE.

Primary Insurance Company_____Phone:_____

Subscriber ID#_____Group#_____

****** If different from patient***: Subscriber Name_____

Date of Birth of Subscriber_____Relationship_____

Secondary Insurance Company_____Phone:_____

Subscriber ID#_____Group#_____

****** If different from patient:*** Subscriber Name_____

Date of Birth of Subscriber:_____Relationship_____

Assignment of Benefits / Authorization to release information:

I hereby authorize Dr Martin Reinke to release any information concerning my care for the purpose of claims to federal, state, city, or town governmental agencies, third party payors of all categories, doctors and hospitals.

I hereby authorize payment directly to MHR Eye Association, the group hospital benefits or insurance benefits including Medicare, herein specified and otherwise payable to me, but not to exceed the regular charges for this period of admission. I understand that I am financially responsible to MHR Eye Association for charges not covered by this authorization.

Signature of Patient_____Date_____

Healthcare Provider Form

Primary Care Physician, Internist or Family Doctor

Name:_____Phone:_____

Address:_____

Condition(s) under management:_____

Endocrinologist

Name:_____Phone:_____

Address:_____

Condition(s) under management:_____

Rheumatologist

Name:_____Phone:_____

Address:_____

Condition(s) under management:_____

Cardiologist

Name:_____Phone:_____

Address:_____

Condition(s) under management:_____

Optometrist:

Name:_____Phone:_____

Address:_____

REFRACTION SERVICE AND FEE

What is a refraction?

Refraction is the process of determining your need for lenses to correct your refractive error, also referred to as your refraction, or your eyeglass prescription.

This is the part of the exam where the doctor, or other staff member flips various lenses inside the phoropter and asks questions like “Better 1 or Better 2”?. We keeping asking these questions until we have helped you achieve the best possible vision.

Why do I have to pay for it?

CMS, the department of the federal government that controls Medicare and Medicaid, has decided that refractions are not a payable part of any eye exam.

CMS, directly under control of the US Congress, has determined this is a “non-covered” service. That means you have to pay for that portion of the eye exam.

Is this new?

Refraction has been a “non-covered” service since Medicare was created in 1965. Since about 2007, Medicare has been enforcing the policy of requiring Ophthalmologist to charge separately for refractions.

As many private insurance carriers adopt the policies of the federal government, many of our contracts with private insurance carriers require us to collect the money from you, as well.

Refraction Fee : $55.00

IF YOU CHOOSE *NOT* TO TAKE YOUR GLASSES OR CONTACT LENS PRESCRIPTION AT THE TIME OF YOUR EXAM. YOU WILL NOT BE RESPONSIBLE TO PAY THE REFRACTION FEE.

I have read the above information and agree to pay Dr Martin Reinke for all services that are not covered under my insurance plan in addition to any co-pays and deductibles.

Patient Signature:_____Date_____

Dr Martin Reinke
Board Certified Ophthalmologist

PATIENT RECORD OF DISCLOSURE

The HIPPA privacy rule gives individuals the right to request a restriction on notes and disclosure of their protected health information (PHI). The individual is also granted the right to request confidential communication, or that a communication be made by alternative means.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (check all that applies)

_____ By home telephone, my number is _____

_____ It is OK to leave me a message with detailed information at home

_____ It is NOT ok to leave me a message with detailed information at home

_____ It Is OK to leave a call back number ONLY at my home number

_____ It is OK to contact me at my work telephone number, which is_____

_____ It is NOT ok to leave me a message with detailed information at work

_____ It is OK to leave a call back number ONLY at my work number

I AUTHORIZE TO DISCUSS MY MEDICAL HISTORY AND RELEASE ANY AND ALL MEDICAL INFORMATION TO THE FOLLOWING INDIVIDUALS: (fill in all that apply)

_____ My spouse, whose name is_____Phone:_____

_____ My parents, whose names are:_____Phone:_____

_____ Other,_____relationship_____Phone:_____

_____ NO ONE OTHER THAN MYSELF

Patient Signature:_____Date:_____

Printed Name:_____

Date of Birth:_____

Name/Signature of legal guardian/caretaker:_____