Welcome to our office!

Please fill out this form as completely as possible and return it to the desk.

Name of Doctor you wish to see:	Dr. Psaltis			Today's Date	
Name				Email Address	
Address				Home Phone	
Apt.#		☐ Male	☐ Female	Cell Phone	
City		State	Zip Code	Work Phone	
Date of Birth		SSN		Fax Phone	
Primary Care Physician				Phone	
Previous Eye Doctor				Phone	
Last Eye Exam				Referred By	

Office Policies

- Current health insurance cards must be presented at each visit. You must provide the office with the name and identification number of any vision plan you wish to use prior to your appointment.
- All copays and deductibles will be collected at the time of visit. Checks are not accepted.
- We reserve the right to reschedule any appointment that arrives more than five minutes late.
- A missed appointment fee of $40 will b applied to patients who cancel or miss appointments with less than 24-hour notice. Multiple missed appointments may result in being unable to schedule future appointments.
- Tint waivers will not be signed.
- Profanity, threats, aggressive or abusive behaviors will not be tolerated.

Medical History

Allergies

Ocular History

Medications

Injuries/ Surgeries

Family Medical History: Note relation to yourself in the box (example: "Mother", "Paternal Grandfather" etc.)

- ☐ Blindness
- ☐ Cataracts
- ☐ Macular Degeneration
- ☐ Glaucoma
- ☐ Retinal Detatchment
- ☐ Crossed Eyes
- ☐ Lupus
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Arthritis
- ☐ Thyroid Disease

Other:

☐ Currently pregnant or nursing.

☐ Doesn't Drive ☐ Drives

Driving Difficulties

☐ Doesn't Use Tobacco ☐ Uses Tobacco

Type/Amount/How Long?

☐ Doesn't Drink Alcohol ☐ Drinks Alcohol

Type/Amt/HowLong

☐ Doesn't Use Illegal Drugs ☐ Uses Illegal Drugs

Type/Amt/HowLong

Have you ever been exposed to or infected with ☐ Gonhorrhea ☐ Hepatitis ☐ Syphilis ☐ HIV

Review of Systems. Please check all that apply to you.

Eyes
- ☐ Vision Loss
- ☐ Blurry Vision
- ☐ Distorted Vision
- ☐ Double Vision
- ☐ Dryness
- ☐ Redness
- ☐ Mucous Discharge
- ☐ Gritty Feeling
- ☐ Itching
- ☐ Burning
- ☐ Excess Watering
- ☐ Light Sensitivity
- ☐ Eye Pain/Soreness
- ☐ Chronic Infection
- ☐ Sties
- ☐ Flashes
- ☐ Floating Spots
- ☐ Tired Eyes
- ☐ Cataracts
- ☐ Diabetic Retinopathy
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Retinal Detatchment

Gastrointestinal
- ☐ Colitis
- ☐ Crohn's Disease
- ☐ Ulcers
- ☐ Constipation
- ☐ Diarrhea

Constitutional
- ☐ Fever
- ☐ Weight Loss/Gain
- ☐ Fatigue
- ☐ Trauma

Integumentary (Skin)
- ☐ Eczema
- ☐ Rosacea
- ☐ Psoriasis

Neurologic
- ☐ Headaches
- ☐ Migraines
- ☐ Seizures
- ☐ Mult. Sclerosis

Endochrine
- ☐ Non Insulin Diabetes
- ☐ Insulin Diabetes
- ☐ Thyroid Dysfunction
- ☐ Hormonal Dysfunction

Respiratory
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema

Cardiovascular
- ☐ Heart Disease
- ☐ Hypertension
- ☐ Hypercholesterolemia

Ears/Nose/Throat
- ☐ Allergies
- ☐ Sinus Congestion
- ☐ Runny Nose
- ☐ Post Nasal Drip
- ☐ Chronic Cough
- ☐ Dry Throat/Mouth

Allergic/Immune
- ☐ Drug Allergies
- ☐ Seasonal Allergies
- ☐ Lupus
- ☐ Arthritis

Lymphatic/Hematologic
- ☐ Anemia
- ☐ Bleeding Problems
- ☐ Leukemia

Musculoskeletal
- ☐ Fibromyalgia
- ☐ Muscular Dystrophy
- ☐ Osteoarthritis
- ☐ Ankylosing Spond.

Genitourinary
- ☐ Kidney Problems
- ☐ Bladder Problems
- ☐ STD's

Please list any other symptoms you may be experiencing.

DELAWARE EYE ASSOCIATES, P.A.

FINANCIAL POLICY

Insurance

If you have insurance, we will do our best to help you receive maximum benefits. Insurance is a contract between you and your insurance company. We are not a party to this contract. We will file insurance claims to your insurance carrier(s) if you have supplied us with all the necessary information. **Our office will not become involved in disputes between you and your insurance company regarding deductibles, copayments, covered charges, secondary insurance, "usual and customary" charges, etc.,** other than supply factual information as necessary. You are responsible for the items listed above, as well as any services received.

Medicare

We do accept assignment from Medicare. **You are responsible for your Medicare deductible and all coinsurance,** unless your secondary insurance covers it for you.

Materials

Orders for glasses or contacts will not be placed without payment in full. We do not keep credit card numbers on file.

Cash Services

We request complete payment be made at time of service. If you are uninsured, the front desk can explain our cash services policies. We do not accept personal checks.

To Our Patients with Medical and/or Vision Benefits:

We will be happy to file your insurance claim forms or take assignment on your medical/vision benefits as designated by:

Plan(s) of which you state you are a member. We will do all we can to help you receive maximum benefits. However, in the event that the plan sponsor determines that you are not eligible for coverage at the time of service, or makes a determination that you are eligible for a reduced level of coverage, by signing this statement you hereby agree to be financially responsible for any and all charges incurred by you and not paid by the plan sponsor. By signing this form, you assign Delaware Eye Associates all patient's rights including, but not limited to, right to payment.

_____ _____

Signature of patient or guardian Date

PRIVACY PRACTICES

1. Designation of certain relatives, close friends and other caregivers as my personal representative:

   I agree that the practice may disclose certain health information to a personal representative of my choosing, since such person is involved with my health care or payment relating to my health care.

   Print Name: _____ Relationship: _____
   Print Name: _____ Relationship: _____
   Print Name: _____ Relationship: _____

2. Acknowledgement of Practice's Notice of Privacy Policies:
   1.The above authorizations are voluntary.
   2.The above authorizations may be revoked by notifying the practice in writing.
   3. The revocation of authorization will not have any effect on disclosures occurring prior to the revocation.
   4. I can request a copy of this signed form.
   5. This form was completely filled in before I signed it and I acknowledge that all of my questions were answered, and that I understand this form.

By signing my name below, I acknowledge that I have read or had the opportunity to read if I so chose and understand the Notice of Privacy Practices and agree to its terms.

Print Name: _____

Signature: _____

Date: _____

For Office Use:

We attempted to obtain written acknowledgement of the receipt of privacy practices, but acknowledgement was not obtained because:

___individual refused to sign

___an emergency situation prevented us from obtaining acknowledgement:

___other