Patient Information - Adult

Please complete all questions on this form

Name: _____ Today's Date: _____/_____/_____

Date of Birth: _____/_____/_____ Sex: M / F (circle one)

Do you wear glasses or contact lenses? ☐ Yes ☐ No How old is your current prescription? _____

Reason for today's visit: _____

_____

When was the approximate onset of the problem? _____

Are you currently experiencing any of the following? Please check all that apply.

- ☐ Abnormal Head Position
- ☐ Double Vision
- ☐ Blurry/ Decreased Vision
- ☐ Droopy Eyelid
- ☐ Dry Eyes
- ☐ Eye Injury
- ☐ Eye Misalignment
- ☐ Headaches
- ☐ Other _____

General Medical History (Please check all that apply)

- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ COPD/ Emphysema/ Asthma
- ☐ Arthritis
- ☐ Heart Disease
- ☐ Bleeding Disorder
- ☐ Cancer
- ☐ Kidney Disease
- ☐ Brain Tumor
- ☐ TIA/ Stroke
- ☐ Neurologic Disorder
- ☐ Seizures
- ☐ Parkinson's Disease
- ☐ Headache/ Migraine
- ☐ Psychiatric Disorder
- ☐ Drug/ Alcohol Addiction
- ☐ Hearing Loss
- ☐ Bell's Palsy
- ☐ Myasthenia Gravis
- ☐ Thyroid Problems
- ☐ Multiple Sclerosis
- ☐ Sjogren's Syndrome
- ☐ Genetic Disease
- ☐ Other _____

List all medications currently being taken: _____

_____

Are you allergic to any medications? ☐ No ☐ Yes Please List: _____

Previous Surgery: _____

Ocular History (Please check all that apply)

- ☐ Amblyopia (Lazy Eye)
- ☐ Strabismus (eye misalignment)
- ☐ Eye Muscle Surgery
- ☐ Cataracts
- ☐ Cataract Surgery
- ☐ Macular Degeneration
- ☐ Retinal Detachment
- ☐ Diabetic Retinopathy
- ☐ Retinal Surgery
- ☐ Glaucoma
- ☐ Glaucoma Surgery
- ☐ Keratoconus
- ☐ Corneal Transplant
- ☐ LASIK / PRK
- ☐ Other _____

How did you hear about us?

_____

Patient Registration

Patient's Name:_____ DOB: _____ ☐ MALE ☐ FEMALE

Address:_____

City/State/Zip:_____ Phone #: _____

Place of employment/Occupation: _____

Email: _____

Parent / Guardian Information (if patient is a minor)

Mother	Father
Name	Name
Date of Birth	Date of Birth
Address (if different from above)	Address (if different from above)
Phone Email	Phone Email

Emergency Contact Information

Name:_____ Phone #: _____

Address: _____

City/State/Zip:_____ Relationship to Patient: _____

Insurance Information

Primary Insurance: _____

Name of Policy Holder:_____ Relationship to Patient: _____

DOB Of Policy Holder: _____Policy #: _____

Secondary Insurance: _____

Name of Policy Holder:_____ Relationship to Patient: _____

DOB Of Policy Holder:_____Policy #: _____

Primary Doctor	Referring Doctor (if different from primary doctor)
Name	Name
Address	Address
Phone Fax	Phone Fax

Please provide your insurance card to copy for our records. Insurance co-pay/deductible and referral (if applicable) are due at the time of service. By signing below, you agree to these terms and authorize Pediatric Ophthalmology & Strabismus Associates to bill your insurance.

_____ _____

Patient/Parent/Guardian Signature Date

Revised 9/2020

Pediatric Ophthalmology &
Strabismus Associates

Patient Privacy Notice

We are required by Federal Law under HIPAA (Health Insurance Portability and Accountability Act) to notify you of our Patient Health Information Privacy Policy. A copy of the policy is available at our front desk, and also on our website. You may review it there at any time, or request a copy to take with you. We are also required to obtain your signature indicating that we have offered you a copy of our Policy.

By signing below, you are confirming that you understand that a copy of our Patient Health Information Privacy Policy is available any time upon request or on our website, www.posa-pa.com.

Patient Name_____

Signature _____
(Parent or Guardian signature if patient is a minor)

Relationship to Patient _____ Date_____

Authorization to Disclose Medical Information

It is the policy of our office to send a summary with the pertinent information to your/your child's primary care physician, or other physicians involved in your care, after each visit, or periodically for three reasons:

1. To document the visit for referrals which may be required by your insurance company
2. To keep your primary care physician updated as to the diagnosis and treatment of your eye condition
3. In response to consultation requests by your primary care physician or another physician who referred you to this office for consultation, second opinions or treatments

☐ I AGREE to the release of medical information to my/my child's primary care physician or other physicians involved in my/my child's medical care as outlined above.

☐ I DO NOT AGREE to the above release of medical information, with the exception of:

_____

Signature: _____

3855 West Chester Pike ● Suite 335 ● Newtown Square, PA 19073 ● P: 610-347-7672 ● F: 610-347-7673
www.posa-pa.com

Revised 9/2020

Pediatric Ophthalmology &
Strabismus Associates

RECORDS RELEASE AUTHORIZATION

DOCTOR OR HOSPITAL: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ FAX: _____

I hereby authorize and request you to release to:

PEDIATRIC OPHTHALMOLOGY & STRABISMUS ASSOCIATES
3855 WEST CHESTER PIKE
SUITE 335
NEWTOWN SQUARE, PA 19073
T: (610) 347-7672 F: (610) 347-7673

The complete medical records in your possession concerning my eye examinations, including all operative reports.

PATIENT NAME: _____ D.O.B.: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

SIGNATURE: _____

RELATIONSHIP TO PATIENT: _____ (If patient is a minor)

Pediatric Ophthalmology & Strabismus Associates

At Pediatric Ophthalmology & Strabismus Associates we strive to adhere to our appointment schedule to minimize waiting times for our patients. Sometimes unforeseen circumstances (emergencies, patients with complex conditions requiring more time, etc.) may cause us to fall behind. If we are running behind schedule, we will attempt to notify you when you check in for your appointment.

In order to help minimize disruptions in our schedule, we have enacted the following policies:

1. If you arrive more than 15 minutes after your scheduled appointment time, you may be asked to reschedule. In that case, you are still responsible for the $25.00 no-show fee.

2. If your insurance requires a referral, the referral must be received by our office prior to your scheduled appointment. If your referral has not been received by 15 minutes after your scheduled appointment time, you will be asked to reschedule. In this case, you are still responsible for the $25.00 no-show fee.

3. If you choose to be seen without a referral (in anticipation of a referral being submitted at a later time), we require a $75.00 deposit prior to being seen. If we are able to obtain a referral, you will be refunded the $75.00 deposit. If we are unable to obtain a referral, you will be billed for the balance of the appointment fee.

4. All no-show fees must be paid in full prior to scheduling another appointment.

Thank you for your cooperation!