Medical History Form Patient Name: _____

Medical History	O diabetes O hypertension (high blood pressure) O elevated cholesterol	O heart disease O thyroid disease (hypo or hyper?) O gastric reflux/ulcer (GERD)	O other _____ _____ _____
Surgical History	O cardiac cath/stent O cardiac bypass O cardiac pacemaker	O thyroid removal O appendix removal O gallbladder removal	O other _____ _____
Ocular History	O cataracts O glaucoma O macular degeneration	O other eye conditions O prior eye surgeries (specify eye and date)	_____ _____ _____
List <u>ALL</u> Medications (including vitamins and supplements)	O no medications _____ _____ _____ _____	_____ _____ _____ _____ _____	_____ _____ _____ _____ _____
Drug Allergies	O no known drug allergy _____	_____ _____	_____ _____
Social History	Smoking O never O former O occasional O daily	Alcohol O none O occasional O daily	Family History O glaucoma O macular degeneration O keratoconus
Review of Systems (CURRENT)	Eyes O eye pain O tearing O redness O vision loss O poor vision Cardiovascular O high blood pressure O rapid heart beat Genitourinary O burning on urination O urinary frequency O incontinence Neurological O headache O seizure O stroke O paralysis Hematologic/Lymphatic O bleeding O anemia	Constitutional O fevers O chills O weight loss Respiratory O congestion O wheezing O shortness of breath Musculoskeletal O joint pain O stiffness O arthritis Psychiatric O anxiety O depression O insomnia Allergic/Immunologic O allergies O hay fever O hives	ENT and Mouth O stuffy nose O cough O ear ache O dry mouth Gastrointestinal O upset stomach O diarrhea O constipation Integumentary/Skin O rash O changing moles Endocrine O diabetes O thyroid abnormalities Pregnancy O Pregnant O Planning Pregnancy O Breastfeeding

Patient Registration

Patient's Name _____"_____"
(First) (MI) (Last) (Nickname)

Gender (CIRCLE ONE) Male Female **Birth Date** ____/_____/_____ **Patient SSN**_____

Address:_____**City**_____**State** _____ **Zip** _____

Primary Phone#: _____ **Phone Type:** ☐ Cell ☐ Home ☐ Work

Secondary Phone#: _____ **Phone Type:** ☐ Cell ☐ Home ☐ Work

E-mail Address: _____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Legally Separated

Ethnicity: ☐ Hispanic ☐ White ☐ African American ☐ Asian ☐ Decline to Specify

Patient's Employer: _____**Position:** _____

Preferred Pharmacy:_____ **City:** _____

Name of Street or cross road: _____**Phone#**: _____

Emergency Contact: _____ **Relationship:** _____

Phone #: _____ **Phone Type:** ☐ Cell ☐ Home ☐ Work

Emergency Contact's Address ***(if different from above)*** _____

Primary Care Physician:_____ **Referring Physician:**_____

Referring Eye Doctor:_____

Subscriber of Insurance/ Responsible Party

Subscriber Name: _____ **DOB:** ____/____/_____ **SSN:** _____

Relationship to Patient:_____

Subscriber Address ***(if different from above)***_____

City _____ **State** _____ **Zip Code**_____

Please Tell Us How You Heard About Us ☐ Internet ☐ Advertisement ☐ Insurance Provider

☐Friend/Relative:(who)_____☐Doctor:_____

Eff: 1/2018

Ajit Nemi, MD, MBA

Notice of Privacy Practices- HIPAA policy information

I, (Print Patient Name) _____, have been notified of Dr. Nemi's privacy policies and procedures. I understand a copy of the policies and procedures will be provided to me upon request.

INFORMATION REGARDING DILATING EYE DROPS

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye.

Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it is best to make arrangements if you are not comfortable driving.

Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize Dr. Nemi and/or such assistants as may be designated to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

Cancellation/No Show Policy: Please call us by 2:00 pm on the day prior to your scheduled appointment to notify us of any changes or cancellations. To cancel a Monday appointment, please call our office by 2:00 pm on Friday. For text and e-mail reminders, you can also use the reschedule option to notify us. If prior notification is not given, you will be charged $50.00 for the missed appointment. The fees are the sole responsibility of the patient/guardian and must be paid in full before the patient's next scheduled appointment.

Patient/Guardian Signature: _____ Date: _____

Witness Signature: _____

Eff: 1/2018

Billing Medical Insurance

- The reason for the exam and the doctor's diagnosis dictate how we must bill our patients. All examinations are billed to your medical, not vision insurance. We are not in network with any vision plans. Initial visits constitute a complete medical examination of the eyes.

- Payment is due at the time services are rendered. Ultimately you are responsible for any remaining balance that your insurance company denies or deems as a non-covered service. To ensure that you receive proper coverage, please contact your insurance company.

Refraction Service and Fee- $30.00

- Most major medical plans do not pay for refraction (Medicare, Medicaid, Tricare, United Healthcare, Blue Cross Blue Shield, Humana, Cigna, Coventry, and Aetna and Misc Insurance). Refraction is how we determine the best-corrected visual acuity as part of assessing the overall health of the eyes. It provides essential information for the physician during the evaluation, especially new patient examinations, regardless of the nature for the visit.

- Refraction requires specialized equipment and is performed by the doctor or specialty-trained technicians. However, despite its importance, some insurance companies choose not to cover this test. We will collect this fee at the time of your service if we know in advance it is not covered. The fee for this charge is $30.00.

Contact Lens Exam and Fees

• Do you wear contacts? Yes/No • If not, are you interested? Yes/No

- **If you know your current contact lens prescription including brand, power, base curve, etc. please provide that information to Dr. Nemi's ophthalmic assistant.**

- The state of Georgia requires that a contact lens evaluation be done every 12 months to update your contact lens prescription and to maintain the health of the eye. This applies to all patients even though you may have worn contact lenses in the past or even if the prescription does not change. The doctor will check and measure the diameter and curvature of the eye and make sure there is no over wear with the contact lens. Contact lenses, regardless of how well they fit reduce the amount of oxygen to the cornea and can increase your risk of dry eyes, inflammation, and infection. Contact lens evaluation fees are not included as part of your comprehensive exam charge. Our fees are below:

Standard Soft, Disposable Lenses: $45.00
Toric, Multifocal, or Monovision Lenses: $65.00
Rigid Gas Permeable (RGP) Lenses, Keratoconus: $85.00
There will be an additional insertion and removal training fee of $20.00 for all new contact lens wearers.

I have read and understand the above information. I accept full financial for the cost of refraction and/or contact lens exam in addition to any other eye exam services. I understand that any copay, coinsurance, or deductible I may have are separate from and not included in either the refraction fee, contact lens fitting fee, or other non-covered procedures.
Please note: All accounts delinquent past 60 days from date of service will incur a $35 service charge. Returned checks will incur a charge of $25.00.

Patient/Guardian Signature: _____ Date: _____

Print Patient Name: _____ Witness Signature: _____

Eff: 1/2018