

Medical History Form



Patient Name: _____

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



LOTUS VISION

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 Decline to Specify

Ethnicity: White Hispanic/Latino African American Asian Decline to Specify

Patient's Employer: _____ Position: _____

Emergency Contact: _____ Relationship: _____

Phone #: _____ Phone Type: Cell Home Work

Primary Care Physician: _____ Referring Physician: _____

Preferred Pharmacy: _____ City: _____

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

Subscriber of Insurance Name: _____ DOB: ___/___/___

SSN: _____ Relationship to Patient: _____

Subscriber Address *(if different from above)* _____

City _____ State _____ Zip Code _____



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 24 hours before your scheduled appointment if you are unable to make your appointment. To cancel a Monday appointment, please leave a voicemail message over the weekend or you can text back on your reminder text to inform the office. **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: _____

Billing Medical Insurance

- ❖ The reason for the exam and the doctor's diagnosis dictates 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).** 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:** _____