PATIENT HISTORY FORM
Please complete and bring with you to your appointment.

Legal Name ______________________________ D.O.B. ____________
Height ____________ Weight ____________ Sex ____________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Occupation ______________________ Retired from ______________________
Name of Family Physician ________________ Phone # ______________________
Date of last visit ____________
List any surgeries you've had in the last five years.
____
____

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

YES	NO	Diabetes (Controlled by Insulin, pills, diet)	YES	NO	Sleep Apnea/Emphysema/Asthma
YES	NO	Heart Disease ______________	YES	NO	Problem lying flat
YES	NO	High Blood Pressure	YES	NO	Claustrophobia/Anxiety
YES	NO	Chest Pain/Angina	YES	NO	Use of oxygen to sleep at night
YES	NO	Irregular heart rate or Pacemaker	YES	NO	Bleeding problems
YES	NO	Neurological disorders ____________	YES	NO	Kidney Failure/Dialysis
YES	NO	Stomach ulcer/Hernia/Reflux	YES	NO	Thyroid Disease
YES	NO	Take Flomax or Coumadin	YES	NO	Wear a hearing aid Lt/Rt/Both
YES	NO	Hepatitis/AIDS/HIV/Tuberculosis	YES	NO	Problems with Anesthesia
YES	NO	Arthritis (type) ______________	YES	NO	Dementia/Alzheimer's
YES	NO	Smoke/Tobacco (how much)________	YES	NO	Cancer (type) ____________
YES	NO	Drink Alcohol (how much)__________	YES	NO	Recreational Drugs ________

FAMILY HISTORY: Has anyone in your immediate family (parents, grandparents, brothers or sisters) had problems with any of the following?

YES	NO	Cataracts ________________	YES	NO	Glaucoma ____________
YES	NO	Retinal ________________	YES	NO	Diabetes ____________
YES	NO	Cancer ________________	YES	NO	Macula Degeneration ________

Other ____

The information that I've given concerning my medical history is true and correct to the best of my knowledge. For my safety, I will obey all instructions and have responsible transportation and home care available.

Signature of patient or caregiver ______________________ Date __________ Time ______

MEDICAL RECONCILIATION

Please list all medications you are currently taking, including over-the-counter medications and supplements, herbal medicines, home remedies, eye drops and vitamins.

MEDICATION NAME	DOSE (How many mg, mcg?)	ROUTE (Mouth, eye, nose)	FREQUENCY (Once Daily, Twice Daily)

ALLERGIES:

MEDICATION NAME	REACTION	WHEN

Are you allergic to latex? ☐ Yes ☐ No

Are you allergic to betadine? ☐ Yes ☐ No

Have you had a newly diagnosed medical problem or illness in the last 30 days?

Explain:____

____

Name of Pharmacy ________________________ Phone # ________________

Patient's or Caregiver's Signature________________________ Date __________

Reviewed by __________________________________ Date __________

PRIVACY NOTICE

If you have questions and/or would like additional information regarding the uses and disclosures of health information, you may contact our Privacy Officer. All requests must be submitted to us in writing on a designated form (which we will provide to you), and returned to the attention of our Privacy Officer at the address below.

CONTACT INFORMATION AND HOW TO REPORT A PRIVACY RIGHTS VIOLATION

Berg Eye Group
2709 Meredyth Drive, Suite 110
Albany, GA 31707
Attn: Privacy Officer

Office: 229-432-7012
Fax: 229-435-0211

If you believe that your privacy rights have been violated or that we have violated our own privacy practices, you may file a complaint with us. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services at Region IV, Office for Civil Rights, U.S. Department of Health and Human Services, Atlanta Federal Center, Suite 3B70, 61 Forsyth Street, SW, Atlanta, GA 30303-8909. Complaints filed directly with the Secretary must be made in writing, name us, describe the acts or omissions in violation of the Privacy Rules or our privacy practices, and must be filed within 180 days of the time you know or should have known of the violation. Complaints submitted directly to us must be in writing and the attention of our Privacy Officer. There will be no retaliation for filing a complaint.

The effective date of this privacy notice is ______________________ 20__________

BY SIGNING BELOW, I HEREBY ACKNOWLEDGE RECEIPT OF THIS PRIVACY NOTICE.

Printed name of patient ______________________________ Date ____________

______________________________ Date ______________________
Signature of Patient or Patient Representative (if applicable)

Representative's Relationship to Patient (if applicable) ______________________

- -

To be completed by Berg Eye Group, P.C.

After a good faith attempt to obtain an acknowledgement of receipt, the patient or representative refused or was unable to sign the Privacy Notice for the following reason(s)

____

____

______________________________ Date ______________________
Signature of Berg Eye Group, P.C.'s Representative

MEDICARE INFORMATION & CONSENT

ASSIGNMENT OF SERVICES:

We accept assignment for MEDICARE service. Accepting assignment means:

(1) Fees are reduced according to **MEDICARE** guidelines.
(2) **MEDICARE** pays 80% of *COVERED* services
(3) **YOU** pay 20% of *COVERED* services.
(4) **YOU** pay the annual deductible.
(5) **YOU** pay for any NON-COVERED services.

SERVICES NOT COVERED BY MEDICARE:

(1) Routine exam – Medicare designates as "routine" diagnosis, such as normal exams, myopia, hypermetropia, presbyopia, astigmatism, screening for disease.
(2) Refraction – the determination of your new eyeglass prescription.
(3) Photography – except for retina and optic nerve photography.
(4) Contact lens services.

MEDICALLY UNNECESSARY SERVICES:

Sometimes Medicare will consider an examination or services as "not reasonable and necessary." If a service is denied by Medicare, you cannot be charged unless:

(1) Prior to performing the service, you were notified and agreed to pay for the services.
(2) We could not reasonably have been expected to know that Medicare would not pay.

LIFETIME FORM

Beneficiary Name ____

Health Insurance ____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Berg Eye Group, P.C. for any services furnished by them. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

Beneficiary Signature ________________________________ Date ______________

(Mdb. Form)

REFRACTION SERVICE AND FEE INFORMATION

Refraction is the process of determining if there is a need for corrective eyeglasses or contact lenses. It is an essential part of an eye examination and necessary to write a prescription for glasses or contact lenses. It is NOT a covered service of Medicare or any other insurance plan. These plans consider a refraction a "vision" service and not a "medical" service.

Our office fee for refraction is $40 and this fee is collected at the time of service, in addition to any co-payment your plan my require.

Should your plan pay us for the refraction, we will reimburse you accordingly.

PATIENT ACKNOWLEDGEMENT

I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service and understand that it is due at the time of the service. I understand that any co-payment, coinsurance or deductible I may have are separate for and not included in the refraction fee. I understand that my glasses or contact lense prescription will not be released until refraction is paid in full.

____ Date ________________________

Patient Signature or Parent of Minor

PATIENT AUTHORIZATION TO RELEASE PERSONAL HEALTH INFORMATION

I hereby authorize Berg Eye Group to release my personal health information to the following person(s):

Name ______________________________ Relationship______________________

Name ______________________________ Relationship______________________

Name ______________________________ Relationship______________________

This person(s) may consist of any relative or friend who may call on my behalf or who may answer the telephone at my residence, anyone who may accompany me to Berg Eye Group or Meredyth Surgery Center, or any other person whom I may identify as authorized to receive my protected health information.

______________________________________ ___________________________

Printed Name of Patient Date

____

Signature of Patient or Patient's Representative

____

Representative's Relationship to Patient (if applicable)

PATIENT INFORMATION FORM

Name ______________________ Home #______________ Cell #______________
Email ______________________ Employer ______________ Work # ______________
Home Address ____
City ______________ State ________ Zip __________ County ______________
SS# ______________ D.O.B. ______________

SPOUSE
Name______________________ SS# ______________ D.O.B. ______________
Employer ______________________ Work # ______________Cell # ______________

COMPLETE IF PATIENT IS UNDER 18 YEARS OLD OR A STUDENT
Name of Father ______________________ SS# ______________ D.O.B. ______________
Employer ______________________ Work # ______________Cell #______________
Name of Mother ______________________ SS# ______________ D.O.B. ______________
Employer ______________________ Work # ______________Cell #______________

EMERGENCY CONTACT
Whom do we notify in an emergency? (Not residing with you)
Name ______________________ Relationship ______________________
Home # ______________ Work # ______________ Cell #______________

INSURANCE INFORMATION
☐ Medicare
☐ Medicaid
☐ Blue Cross / Blue Shield ☐ VIP ☐ PPO ☐ GA ☐ AL
☐ United Health Care
☐ Workers Compensation (job injury) Employer ______________________
☐ Aetna
☐ Other Medical Insurance Company ______________________

AUTHORIZATION TO RELEASE INFORMATION
I hereby authorize the above doctors to release any information required to process my medical claims. I permit a copy of this authorization to be used in place of the original and request payment of benefits to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

I hereby authorize Berg Eye Center to use my cell # for communication.

Signature of patient ______________________________ Date ______________

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-229-432-7012.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-229-432-7012.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-229-432-7012. 번으로 전화해 주십시오.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-229-432-7012.

�ુના: જો તમે �જરાતી બોલતા હો, તો િન:�લ્કુ ભાષા સહાય સેવાઓ તમારા માટ� ઉપલબ્ધ છ. ફોન કરો

1-229-432-7012.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-229-432-7012.

ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-229-432-7012.

ध्यान द�: य�द आप �हदी बोलते ह �तो आपके िलए मुफ्त म� भाषा सहायता सेवाएं उपलब्ध ह।�

1-229-432-7012. पर कॉल कर�।

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele

1-229-432-7012.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-229-432-7012.

برقم اتصل .بالمجان لك تتوافر ةىاللغو ساعدةالم خدمات فإن ،اللغة اذكر تتحدث كنت إذا :ملحوظة 1-229-432-7012-

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-229-432-7012.

شما یبرا گانیرا بصورت یزبان لاتیتسه ،دیکن یم گفتگو یفارس زبان به اگر :توجه

.دیریبگ تماس با .شدبا یم فراهم 229-432-7012

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-229-432-7012.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-229-432-7012

まで、お電話にてご連絡ください。