

Medical Insurance Information

Patient _____ DOB ____/____/____ Age ____ Sex ____
Last First

Social Security # ____ - ____ - ____ Phone (____) _____ Marital Status _____

Home Address _____
Street City State Zip

Employer _____
Street City State Zip

Parent, Spouse, or Responsible Party _____
Name Relationship

Contact Information _____
Address Phone

Emergency Contact _____
Name Address Phone

Referred by _____
Name Address Phone

Are you presently a member of an HMO health plan? YES NO (please circle)

Are you currently enrolled in Hospice? YES NO (please circle)

Primary Insurance:

Insurance Company _____ Group Policy # _____

Policy Holder _____ Member/ID # _____

Date of Birth ____/____/____ Sex ____ Patient Relationship to Policy Holder _____

Primary Care Physician _____ Referring Medical Group _____

Secondary Insurance:

Insurance Company _____ Group Policy # _____

Policy Holder _____ Member/ID # _____

Date of Birth ____/____/____ Sex ____ Patient Relationship to Policy Holder _____

Primary Care Physician _____ Referring Medical Group _____

Consent for use and disclosure of protected health information

By signing below, you consent to the use and disclosure of your protected health information by our office for treatment, payment, and health care operations. For a more detailed explanation, please review our Notice of Information Practices posted at the front desk.

Patient or Guardian's Signature _____ Date _____

Name _____
Last First Dr. Mr. Ms. (Circle One)

Home Tel (_____) _____

Address _____

Today's Date ____/____/____

City and State _____

Zip _____

Employer _____

Occupation _____

Employer Address _____

Employer Tel (_____) _____

Who referred you? _____

Reason for visit? _____

Are you currently enrolled in Hospice? YES NO (please circle)

Do you have allergies to any medications? YES NO (please circle)

If yes, please explain _____

Have you ever had any surgery? YES NO (please circle)

If yes, please explain _____

Do you take any medications? YES NO (please circle)

If yes, list _____

Have you had any of the following problems? If yes, please explain: (please circle)

Chronic fever, weight loss/gain, fatigue? YES NO

Ear/nose/throat problems? (hearing loss, sinus problems, sore throat) YES NO

Heart problems: (chest pain, irregular heart beat hypertension) YES NO

Respiratory problems? (shortness of breath, asthma, bronchitis) YES NO

Gastrointestinal problems? (heartburn, abdominal pain, diarrhea) YES NO

Urinary Problems? (pain, bladder problems, blood in urine) YES NO

Musculoskeletal problems? (aches, arthritis, swollen joints) YES NO

Psychiatric problems? (depression anxiety) YES NO

Do any medical or eye diseases run in the family? YES NO

Do you smoke or consume alcohol? If yes, how much? YES NO

Women, are you pregnant: YES NO
If yes, how many months? _____

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

Home Telephone: _____

OK to leave message with detailed information
OR

Leave Message with call-back number

Work Telephone: _____

OK to leave message with detailed information
OR

Leave Message with call-back number

Written Communication

OK to mail to my home address

OK to mail to my work/office address

OK to fax to this number: _____

Other: _____

Patient Signature

Date

Print Name

Birth date

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use of disclosure of, and request for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency

Date	Disclosed to Whom Address or Fax Number	(1)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized

(2) Type Key: T= Treatment Records; P=Payment Information; O= Healthcare Operations; A= Authorization on File; D= Discretionary

(3) Enter how disclosure was made: F= Fax; P= Phone; E= Email; M= Mail; O= Other

CLAREMONT EYE ASSOCIATES
JOHN J. MCDERMOTT, M.D.
MARJORIE A. PARKER, M.D.
JOHN J. MCDERMOTT III, M.D.
SUNIL M. SHIVARAM, M.D
655 East Foothill Blvd., Claremont, CA. 91711
Telephone (909) 624-8077/Fax (909) 624-0542

INSURANCE NON-COVERED SERVICE AGREEMENT

NOTICE TO BENEFICIARY

Insurance companies will only pay for services that it determines to be "reasonable and necessary". If your insurance company determines that a particular service is not "reasonable and necessary" under their set policy they will deny payment for that service. If your insurance denies your service you will be responsible for payment.

BENEFICIARY AGREEMENT

I AGREE TO BE PERSONALLY AND FULLY RESPONSIBLE FOR ANY UNPAID BALANCE THAT MY INSURANCE CARRIER DENIES.

Print Name _____ Insurance Co. _____

Signed _____ Date _____

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