RICHARD K. MARSCHNER JR., M.D., P.A.
Comprehensive Ophthalmology

Thank you for scheduling your eye exam with us. Please take a few moments to fill out the enclosed forms and bring them to your appointment. The forms are required by Medicare and most insurers; but more importantly, they will help Dr. Marschner in evaluating your eyes and general health as part of your exam. **Please remember to bring your insurance card(s) to your appointment.**

During your visit, Dr. Marschner will review your ophthalmic history and your medical history. He will conduct a thorough examination of the complete anatomy of your eyes to detect Ocular Disorders (e.g., Glaucoma, Cataract, and Macular Degeneration). Your eyes will be dilated to facilitate examination of the inside of your eyes. Since the dilation process alone can take up to 20 minutes, please plan on spending a minimum of 1 hour at our office for your initial visit. Dr. Marschner will personally discuss any findings with you, so that you can understand any conditions present and any treatment necessary. A prescription for eyeglasses will be provided at the visit if needed.

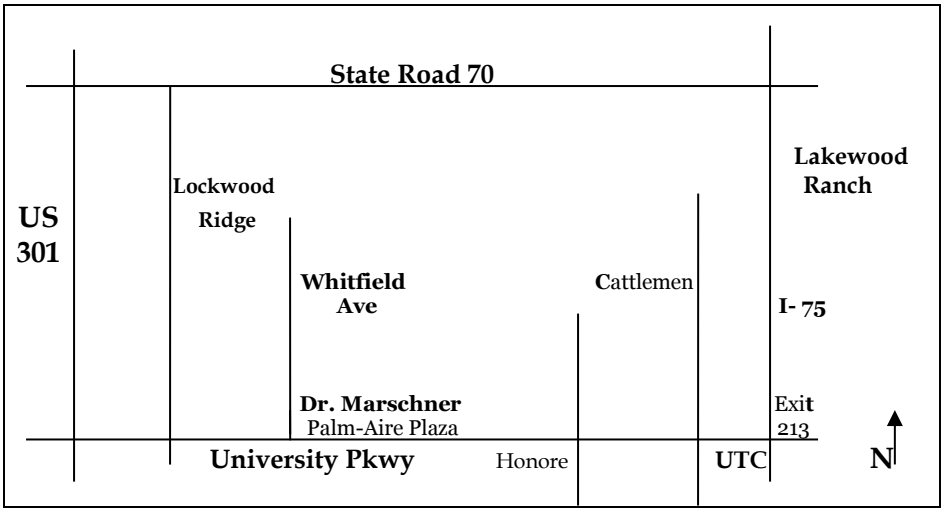
A Contact lens prescription can be given and updated if you wear your contact lenses to the visit and you bring your prescription information. A new contact lens fitting will be required if records of the exact base curve, diameter, power, brand and model of the contact lenses are not brought to the visit. (All of these parameters are on the original packages.)

If you have sunglasses, please bring them with you to wear after your eyes have been dilated. This will cut down on glare from the sun after your visit.

If you have any questions prior to your visit with us, please feel free to phone our office. We look forward to meeting you.

Sincerely,

Dr. Marschner and Staff



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MARSCHNEREYEMD.COM

RICHARD K. MARSCHNER JR., M.D., P.A.

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Patient Registration

1. Name: _____ Date: _____

2. Local Address: _____
   Street City State Zip

3. Out of State Address: _____
   Street City State Zip

4. Preferred Phone: _____ Other Phone: _____

   E-Mail: _____

5. Date of Birth: _____ Age: _____ Male _____ Female _____

6. Marital Status: □ Single □ Married □ Widowed □ Divorced □ Partner

7. Spouse/Partner's Name: _____ Date of Birth: _____

   Emergency Contact: _____ Relationship: _____

   Preferred Phone: _____ Other Phone: _____

8. Employer Name: _____ Phone: _____

9. How were you referred to our office? □ Another Doctor (Name) _____

   □ Friend/Family member (Name) _____ □ Website/Other

10. Who is your primary medical doctor? _____

Health Insurance Information

Do you have Medicare? □ Yes □ No

If not Medicare, what is the name of your primary **medical** insurance?

_____

Do you have secondary **medical** insurance? □ Yes □ No

Secondary Insurance Name: _____

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Today's date: _____

Name: _____

Date of Birth: _____

Who is your medical doctor? _____

_____

Do you have any of these eye symptoms?

☐ Blurred distance vision ☐ Glare, halos around lights
☐ Blurred reading vision ☐ Itching or burning eyes
☐ Constant double vision ☐ Eye matter/crusting
☐ Flashing lights or floaters ☐ Foreign body sensation
☐ Eye tearing ☐ Red Eyes ☐ Dry Eye ☐ Eye Pain
☐ Other: _____

List of *MEDICATIONS* you are currently taking:
Including vitamins/supplements
☐ **None** ☐ Aspirin on a daily basis

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

List each *EYE* medication you currently take:

☐ **None** ☐ Artificial Tears

Medication Name	Amount	Times per day
_____	_____	1 2 3 4
_____	_____	1 2 3 4
_____	_____	1 2 3 4

Any known *ALLERGIES* to medications:

☐ **None Known** ☐ Yes, which ones? (list below)

Medication Name	**What reaction did you have?**
_____	_____
_____	_____
_____	_____

Do you use? ☐ Tobacco ☐ Alcohol # Drinks/wk _____
☐ **None**

Past/Current Occupation: _____

Have you ever had any of these eye conditions?

☐ Cataract ☐ Serious eye injury
☐ Glaucoma ☐ Iritis/uveitis
☐ Macular degeneration ☐ Lazy eye
☐ Wore eye patch as a child ☐ Retinal detachment
Other: _____

Have you ever had any of these conditions?

☐ **None** ☐ Headaches
☐ Stroke ☐ Dizziness ☐ High blood pressure
☐ Arthritis ☐ Allergies ☐ Heart disease
☐ Diabetes ☐ Aids, HIV ☐ Lung diseases
☐ Cancer ☐ Anemia ☐ Thyroid disease
☐ Other: _____

Have members of your family had any of these conditions?
(Parents, Siblings, Grandparents)

☐ **Unknown** ☐ Lung diseases
☐ Stroke ☐ High blood pressure
☐ Arthritis ☐ Heart disease
☐ Diabetes ☐ Inflammatory disorder
☐ Cancer: _____

Have members of your family had any *eye* diseases?
(Parents, Siblings, Grandparents)

☐ **Unknown** ☐ Blindness
☐ Glaucoma ☐ Diabetic eye disease
☐ Cataract ☐ Retinal detachment
☐ Iritis/uveitis ☐ Macular degeneration
☐ Crossed eyes ☐ Other: _____
☐ Poor Vision

Please list <u>all</u> *EYE* surgeries you have had:

☐ **None**

Type of Eye Surgery	Which Eye		Year
_____	Right	Left	_____
_____	Right	Left	_____
_____	Right	Left	_____
_____	Right	Left	_____

ALL *other* surgeries you have had:

☐ **None**

Type of Surgery	Year
_____	_____
_____	_____
_____	_____
_____	_____

What non-surgery illnesses have caused a hospital stay?

_____
_____

What was the approximate date of your last eye examination? _____

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REVIEW OF SYSTEMS

Name: _____ Today's Date: _____

In each area, if you are not having any difficulties, please check "**No Problems**". If you are experiencing any of the symptoms listed, **PLEASE CIRCLE THOSE THAT APPLY.** If you have any questions about this, please ask the Nurse, or your doctor.

Const. (Health in General) ☐ No Problems Lack of energy, unexplained weight gain or weight loss, loss of appetite, fever, night sweats, pain in jaws when eating, scalp tenderness, prior diagnosis of cancer
Other: _____

Ears, Nose, Mouth & Throat ☐ No Problems Difficulty with hearing, sinus problems, runny nose, post-nasal drip, ringing in ears, mouth sores, dry mouth, ear pain, nosebleeds, sore throat, facial pain or numbness
Other: _____

C-V (Heart & Blood Vessels) ☐ No Problems Irregular heartbeat, racing heart, chest pains, swelling of feet or legs, pain in legs with walking Other: _____

Resp. (Lungs & Breathing) ☐ No Problems Shortness of breath, night sweats, prolonged cough, wheezing, sputum production, prior tuberculosis, pleurisy, oxygen at home, c-pap, coughing up blood, abnormal chest x-ray Other: _____

GI (Stomach & Intestines) ☐ No Problems Heartburn, constipation, intolerance to certain foods, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, unexplained change in bowel habits, incontinence Other: _____

GU (Kidney & Bladder) ☐ No Problems Painful urination, frequent urination, urgency, prostate problems, bladder problems, impotence Other: _____

MS (Muscles, Bones, Joints) ☐ No Problems Joint pain, aching muscles, shoulder pain, swelling of joints, joint deformities, back pain Other: _____

Integ. (Skin, Hair & Breast) ☐ No Problems Persistent rash, itching, new skin lesion, change in existing skin lesion, hair loss or increase, breast changes Other: _____

Neurologic (Brain & Nerves) ☐ No Problems Frequent headaches, double vision, weakness, change in sensation, problems with walking or balance, dizziness, tremor, loss of consciousness, uncontrolled motions, episodes of visual loss Other: _____

Psychiatric (Mood & Thinking) ☐ No Problems Insomnia, irritability, depression, anxiety, recurrent bad thoughts, mood swings, hallucinations, compulsions
Other: _____

Endocrinology (Glands) ☐ No Problems Intolerance to heat or cold, menstrual irregularities, frequent hunger/urination/thirst, changes in sex drive
Other: _____

Hematologic (Blood/Lymph) ☐ No Problems Easy bleeding, easy bruising, anemia, abnormal blood tests, leukemia, unexplained swollen areas Other: _____

Allergic/Immunologic ☐ No Problems Seasonal allergies, hay fever symptoms, itching, frequent infections, exposure to HIV Other: _____

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CREDIT POLICY AND FINANCIAL AGREEMENT

- Each patient, ***and not their insurance company***, is responsible for the payment of all charges. Payment is customarily made at the time that services are rendered, unless special arrangements are made in advance. If our doctor is a participating physician for your primary insurance plan, payment for any deductibles, co-pay amounts and non-covered services will be due at the time of service.

- It should be remembered that eye examinations, or certain other ophthalmic services, are not always covered by every insurance company. Even within the same insurance plan there may be many individual variations. It is your responsibility to know whether or not your insurance plan will cover the services that you receive in our office. It is simply not possible for the staff of this office to know how each and every individual insurance plan works.

- A refraction (the measurement of your eyes for a glasses prescription by either the doctor, or one of the ophthalmology technicians) is typically ***not a covered benefit of your insurance plan***. In the course of your examination, when it is necessary to perform a refraction, it is with the understanding that you will be held financially responsible for this charge.

- This office accepts assignment for Medicare patients. However, each patient is responsible for payment of all non-covered costs. Examples of non-covered Medicare services would be: the refraction for glasses that is part of almost every comprehensive eye examination, the annual Medicare deductible, and any remaining balance of Medicare allowable fees not covered by a supplemental insurance plan. It is important to understand that when a participating physician accepts assignment from Medicare, it does not mean that whatever Medicare pays is to be considered payment in full. Medicare has never paid 100% of any charge. Many other insurance companies follow this same basic philosophy. The Stark II legislation, recently passed by the United States Congress, prohibits this office from extending courtesy discounts and/or professional write-offs.

- Payment on all accounts billed is expected within 30 days. If payment is not received within 30 days, a monthly administrative fee may be added to your account to partially defray postage and other office costs generated by multiple billings.

- By signing below, I agree to the above terms and I agree to pay any collection costs and/or reasonable attorney's fees, if a delinquent balance is placed with a collection agency and/or attorney for collection, or suit.

ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, participating private insurance, and any other health plan to Richard K. Marschner Jr., M.D., P.A. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges, whether or not these charges are paid by my medical insurance. I hereby authorize Richard K. Marschner Jr., M.D., P.A. to release any and all information necessary to secure payment.

_____ Date: _____
Patient Signature (or Parent/Guardian if applicable)

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Privacy Acknowledgment

I have received a copy of the Richard K. Marschner Jr., M.D., P.A. Notice of Privacy Practices.

Today's Date: _____

Patient's Date of Birth: _____

Signature of Patient: _____

Signature of Parent or Guardian (if Applicable): _____

My medical information may be shared with:

_____

_____

_____