

Dana P. Tannenbaum, M.D.

Patient General Information

Date: _____

Referred by: _____

Patient: _____ Male Female
(First) (Middle) (Last)

Address: _____
(Street)

(City) (State) (Zip Code)

Phone # _____ Age: _____ Date of Birth: _____

Occupation: _____ Social Security #: _____

Employer: _____ Phone #: _____

Employer's Address: _____

Spouse's Name: _____ Occupation: _____

Employer: _____ Phone #: _____

Relative or Friend: _____ Phone#: _____

Patient Insurance Information

Please fill in the following as completely as possible. **Please bring insurance card(s)**

Insurance Company Name: _____ Insured's Name: _____

I.D. # _____ Policy # _____ Group #: _____

Billing Address: _____

Please fill in the following as completely as possible. **Please bring insurance card(s)**

Insurance Company Name: _____ Insured's Name: _____

I.D. # _____ Policy # _____ Group #: _____

Billing Address: _____

Medicare Number: _____ Is Medicare Primary? Yes No

A Center for VisionCare is a Participating Provider--Assignment is Accepted.

Patient's Medical Doctor

Medical Doctor: _____ Phone: _____

Address: _____

City _____ State _____ Zip Code _____

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Patient Medical Information

Please tell us the name of your Doctor and tell us a little of your medical history.

Medical Doctor: _____

Address: _____

City: _____ Zip: _____

Tel #: (____) _____

Please check any of the following that may apply to you:

- High blood pressure Heart disease Artery disease Gastritis
- Gastric Ulcer Kidney disease Thyroid disease Poor appetite
- Diabetes Arthritis Heartburn Indigestion Circulatory Problems

Do you have any: Difficulty breathing Difficulty sleeping

Do you smoke? Yes No Do you drink alcohol? Yes No

Have you had any operations? Yes No

If yes, please list:

Please list all medications you are taking (if unsure, please check labels):

Name: _____ Dosage: _____ Times Daily _____

Name: _____ Dosage: _____ Times Daily _____

Name: _____ Dosage: _____ Times Daily _____

Name: _____ Dosage: _____ Times Daily _____

Name: _____ Dosage: _____ Times Daily _____

Name: _____ Dosage: _____ Times Daily _____

If you have any other Doctors whom you see on a routine basis, please write this information on the other side of this sheet. Please use this space for any other comments you may have about your general health:

Are you allergic to any medications?

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Ophthalmological Patient Information

We would like you to share with us your present eye problems and symptoms and any past history and/or surgery.

In the past, have you had any eye surgery for:

- Cataracts Laser Surgery Glaucoma Eyelid reconstruction/cosmetic
 Other _____

Do you have any chronic condition:

- Glaucoma Diabetic Retinopathy Other _____

Currently do you have any of the following symptoms:

- Redness Swelling Tearing Irritated feeling Black spots Flashes
 Foreign body feeling
 Other _____

The above symptom(s) are present:

- All the time Just in morning Occasionally Worse by end of day

How long have you noticed any of these symptoms:

Please list any drops, ointments, or pills that you are taking for your eyes:

- Name of Drop: _____ Right eye Left eye Both ____ Times Daily
Name of Drop: _____ Right eye Left eye Both ____ Times Daily
Name of Drop: _____ Right eye Left eye Both ____ Times Daily
Name of Ointment: _____ Right eye Left eye Both ____ Times Daily
Name of Ointment: _____ Right eye Left eye Both ____ Times Daily
Name of Pill: _____ _____ Times Daily
Other: _____ Right eye Left eye Both ____ Times Daily

Other information you would like to tell us about: _____

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Signature on File, Assignment of Benefits, Financial Agreement

Beneficiary Name _____ Medicare Number _____

1. MEDICARE: I request that payment of authorized Medicare benefits be made on my behalf to A Center for VisionCare Surgical and Medical Group (ACVC). I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. ACVC accepts the charge determination of the MediCare carrier as the full charge, and I am responsible only for the deductible, coinsurance and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

2. MEDIGAP: I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claims forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to ACVC, if possible or otherwise to me.

3. RELEASE OF INFORMATION: A Center for VisionCare may disclose all or any part of my medical record and/or financial ledger to any person or corporation (1) which is or may be liable or under contract to ACVC for reimbursement for services rendered, and (2) any health care provider for continued patient care. ACVC may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original. I authorize ACVC to release my medical information to _____ initials _____.

4. OTHER INSURANCE: I understand that ACVC maintains a list of health care services plans with which it contracts. A list of such plans is available from the business office. And that ACVC has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay full charges of all services rendered to me by ACVC if I belong to a plan that does not appear on the above mentioned list.

5. NON-COVERED SERVICES: I understand that ACVC contracts with health care service plans (i.e., HMOs, PPOs) relate only to items and services which are "covered" by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient; and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with ACVC to obtain necessary health care service plan authorizations.

6. FINANCIAL AGREEMENT: I agree that in return for the services provide to the patient by ACVC, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to ACVC for payment. If an account is sent to an attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to ACVC. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to ACVC. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

Beneficiary Signature or Authorized Party

Date