GHANSHYAM M. PATEL M.D.,P.A.
Ophthalmologist
Disease and Surgery of the Eye

( ) 12002 S. Highway 6 #100
Sugar Land, TX 77498

( ) 10905 Memorial Hermann Dr. #202
Pearland, TX 77584

(281) 240-0950

NEW PATIENT INFORMATION FORM

Welcome to our office, please complete this form and return it to the front desk so that we can most effectively meet your needs.

Patients Name: _____ Date: _____
Last First Middle

Mailing Address: _____ Apt No.: _____

City _____ State: _____ Zip Code : _____ Tel. No.: _____

Social Security No.: _____ Cell No: _____

Email Address: _____ Text Message: Y N

Race: _____ Ethnicity Circle One: Hispanic Non-Hispanic Language: _____

Referring Physician: _____ Tel. No.: _____

Patient Sex: MALE FEMALE Birth Date: _____ Age: _____ Marital Status: S M W D

Occupation: _____ Employer: _____

Work Phone: _____ Spouse: _____

(If insurance is not able to process claim are you personally responsible for the payment of your fees: YES NO

If no, who is? _____
(If Workman's Compensations please give name , address and phone number of the person we can contact to verify incident).

Responsible Person: _____ SS#: _____ D.O.B.: _____ Sex: _____

Street Address: _____ City: _____ State: _____ ZIP: _____

Guarantor's Employer: _____ HM PH#: _____ WK PH#: _____

INSURANCE: (Please list all insurance coverage you have. If Medicare or Medicaid, please list you're number including the letter. If you have private or secondary insurance please list this also.)

Medicare/Medicaid#: _____ Insurance Co.: _____

Name of Insured: _____ Birthdate of holder: _____

Policy/Mem. ID#: _____ Group Number: _____

I authorize GHANSHYAM M. PATEL M.D.P.A. the release of any medical information necessary to process insurance claims. Also authorize to retain copy of Credit Card information on file for future payment due on the account for any medical, surgical co-ins, co-pay and or deductibles since these will be my responsibilities to pay GHANSHYAM M. PATEL M.D.P.A.

Signature: _____ **Date:** _____

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OPHTHALMOLOGY
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Board Certified Ophthalmologist

Patient History Questionnaire

Patient Name: **Date:**
Date of Birth:

Please state reason for visit:

Referring Physician Name:

Previous eye conditions and surgeries: _____**None**

List ALL Medical Conditions: _____**None**

__Diabetes ___years __High Blood Pressure __Heart Disease __HIV / AIDS
__Kidney Dialysis/Disease __Bleeding Disorder __Cancer __Thyroid Disease
__Lung Disease __Vascular Disease __Stroke __High Cholesterol

List Other Medical Problems and Major Surgeries: _____**None**

List ALL Current Medication (include non-prescription drugs): _____**No Medications**

Allergies and Drug Reactions: _____**No Known Allergies**

Social History: Circle answer
Marital Status: _____ Occupation: _____
Do you drink alcohol? No Yes (if yes, how often)_____
Do you smoke or have you ever?
No Yes (if yes, current packs per day)_____
Do you abuse drugs? No Yes (if yes, explain)_____
Do you drive? No Yes
Do you live alone? No Yes
Do you reside in a skilled nursing facility / assisted living? No Yes

Family History:
Any relative with: ___ Glaucoma? _____ Diabetes _____
___ Macular Degeneration? _____ Hypertension _____
___ Other?: _____ Cholesterol _____

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Mailing Address: P. O. Box 17895, Sugar Land, TX 77496-7895

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ACKNOWLEDGEMENT OF REVIEW OF
NOTICE OF PRIVACAY POLICY AND PRACTICES

As the law requires, neither your physician nor any member of his staff are permitted to give or discuss any information, whether written or oral, regarding your condition or treatment to any third party (relative, friend, co-worker, employer, insurance company, etc.) without your express written authorization. However, a letter of consultation of you condition will be sent to the referring physician and your primary care/referring doctor.

I have reviewed this office's Notice of Privacy Policy and Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____
Signature of Patient or Personal Representative

_____
Date

Are there other family members or persons with whom you authorize us to discuss your medical information? Yes No If yes:

Name: _____

Phone: _____

Relationship: _____

Name: _____

Phone: _____

Relationship: _____

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OPHTHALMOLOGY

Disease and Surgery of the Eye

APPOINTMENT CANCELLATION AND PROOF OF INSURANCE POLICY
Effective 10/2013

Patient Name: _____ Date of Birth: _____

Welcome to our office! We are pleased that you have chosen us to take care of your medical needs. To make our time together most efficient and enjoyable, we have listed several office policies. Please read them carefully.

YOUR APPOINTMENT: Be on time for your appointment, preferably 10-15 minutes prior to your appointment. If you are late more then 15 minutes, you risk cancellation of your appointment.

CANCELLATION OR RESCHEDULE POLICY: We require a minimum of 24 hour notice to cancel or rescheduled appointment. All no show, cancellation or rescheduled appointments less then 24 hours will have a $30 charge applied to your account. For your convenience, our answering services is available 24 hours a day for you to leave message.

PROOF OF INSURANCE: You are required to bring your **CURRENT** insurance card to **every** appointment. We cannot file claim or verify insurance without this information. If Insurance information is not provided at the time of check in will result in reschedule your appointment.

I acknowledge that I am fully responsible for making and keeping my appointment as well as providing proof of insurance at every appointment.

I have read and completely understand my obligation to the office polices.

Signature of Patient: _____ Date: _____

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OPHTHALMOLOGY

Disease and Surgery of the Eye

Dilation of Eyes: Due to the nature of your eye problem, it will be necessary to put drops in your eyes, which will dilate them. This means that the pupils will become and stay enlarged, letting in more light and may cause blurred vision particularly at near. A few patients have expressed concern regarding their ability to function after dilation. It has been our experience that the near vision is affected far more than the distance, and that most individuals are able to "get around", although some caution may be necessary in order to give the doctor dull enlarged view of the back of the eye. This is vital part of the retinal examination.

Assignment of Benefits: I hereby assign payment directly to the physician(s) accepting this assignment of medical benefits applicable and otherwise payable to me.

Patient Financial Responsibilities: I understand that I am financially responsible for charges not covered by this assignment, including any insurance deductible, copayment, or any charges, which the insurance carrier declines to pay. It is further agreed that any credit balance resulting from payment of insurance or other sources may be applied to any other accounts allowed to send physician by the insured or his/her family. Any overpayment that I make to the Ghanshyam M. Patel MDPA will be applied as a credit to my account. If I prefer a refund, I will need to contact the billing department for that request and to confirm my mailing address to issue that refund. Understand that if for any reason my insurance company does not ay my bill within 90 days, I will be responsible. Any return checks will incur a $20 returned checks fee. In the event the account becomes delinquent and is turned over to a collection agency, I am responsible for any collection, court, or attorney fees. If I would like a copy of the billing policy of responsible of Ghanshyam M. Patel MDPA, it is available to me upon request by contacting the billing department.

Release of Information: The physician(s) may disclose all or part of the patient's record to any person or corporation which is or may be liable under the contract to the physician(s), to the patient, to a family member, or employer of the patient for all or part of the physician(s) charge, including but not limited to insurance companies, workers compensation carriers, welfare funds, or the patient's employer. The physician may also disclose at his discretion all or part of the patient record to other health-care professionals and in their staff for the purpose of coordinating the patient's medical care. This includes but is not limited to the patient's primary care physician and referring physician. The patient or responsible party may request and receive all or part of the patient's record at anytime.

Medicare and Medicaid patient's certification-payment classification authorization to release information and payment requests: I certify that information given by any and applying for payment under Title XVIII and/or XIX of the Social Security Act is correct. I authorized any holder of medical or other information about me to the Social Security Administration or its intermediary carriers, any information needed for this or any related Medicare, Medicaid or other third party claim. I request that payment of authorized benefits may be on my behalf. I signed benefits payable for physician(s) services. I understand that I am responsible for my health insurance collectibles and co-insurance.

_____ _____

DATE **SIGNATURE OR PATIENT OR RESPONSIBLE PARTY**

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