





GHANSHYAM M PATEL MDPA  
Disease and Surgery of the Eye  
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**

<input type="checkbox"/> Diabetes ___years	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> HIV / AIDS
<input type="checkbox"/> Kidney Dialysis/Disease	<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Cancer	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Vascular Disease	<input type="checkbox"/> Stroke	<input type="checkbox"/> 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 \_\_\_\_\_

12002 S. Highway 6 #100, Sugar Land, TX 77498 PH: (281)240-0950, FAX: (713)240-0970  
Mailing Address: P. O. Box 17895, Sugar Land, TX 77496-7895



**GHANSHYAM M. PATEL M.D.,P.A.**  
**OPHTHALMOLOGY**  
**Disease and Surgery of the Eye**  
**Board Certified Ophthalmologist**

---

**ACKNOWLEDGEMENT OF REVIEW OF  
NOTICE OF PRIVACY 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: \_\_\_\_\_



**GHANSHYAM M. PATEL M.D., P.A.**  
**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 than 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 than 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 policies.

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to patient if not self: \_\_\_\_\_



**GHANSHYAM M. PATEL M.D., P.A.**  
**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 M.D.P.A 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 pay my bill within 90 days, I will be responsible. Any returned 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 M.D.P.A, 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**