PATIENT INFORMATION

PATIENT NAME: _____
LAST FIRST MIDDLE

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ CELL PHONE: _____

EMAIL ADDRESS: _____

DATE OF BIRTH: _____/_____/_____ SEX (circle one): MALE / FEMALE

SOCIAL SECURITY NUMBER: _____/_____/_____

PATIENT RELATIONSHIP TO THE RESPONSIBLE PARTY (circle one): SELF SPOUSE CHILD OTHER

MARTIAL STATUS (circle one): SINGLE MARRIED DIVORCED WIDOWED OTHER

PRIMARY CARE PHYSICIAN: _____ REFERRED BY: _____

PCP PHONE: _____ PHONE: _____

PATIENT'S EMPLOYER INFORMATION

Ethnicity (Choose one): Hispanic or Latino Not Hispanic/Latino Unknown Decline to specify

Race: _____

Pharmacy: _____ Pharmacy Location: _____

RESPONSIBLE (OR INSURED) PARTY INFORMATION

RESPONSIBLE PARTY NAME: _____
LAST FIRST MIDDLE

ADDRESS: _____

DATE OF BIRTH: _____/_____/_____ SEX (circle one): MALE / FEMALE

HOME PHONE: _____ WORK PHONE: _____

SOCIAL SECURITY NUMBER: _____/_____/_____

HEALTH HISTORY

Yes	No		Yes	No	
☐	☐	Asthma	☐	☐	Head or Spinal Injuries
☐	☐	Kidney Disease	☐	☐	Seizures, Convulsions, or Fainting
☐	☐	Tuberculosis	☐	☐	Extensive Confinement by Illness or Injury
☐	☐	Diabetes IDDM/Type II ____ # of yrs ____	☐	☐	Are you allergic to latex?
☐	☐	Insulin	☐	☐	Suffering from any other disease
☐	☐	Migraines	☐	☐	Carotid Artary Disease
☐	☐	Psychiatric Disorder	☐	☐	Permanent Defect from Illness, Disease or injury
☐	☐	Any nervous disorder	☐	☐	(Women) Are you Pregnant?
☐	☐	Heart Disease	☐	☐	High Blood Pressure ____ # of yrs ____
☐	☐	Ulcer	☐	☐	Stroke
☐	☐	Sickle Cell Anemia	☐	☐	HIV
☐	☐	Do you Smoke?	☐	☐	Are your immunizations current?
☐	☐	Do you Drink?	☐	☐	Cancer
☐	☐	Within the last twelve (12) months have you taken any illegal substances?			

Please List All Medications You Are Currently **TAKING:**	Please **List** all Medications You Are Allergic to **AND REACTIONS**

YOUR OCULAR HISTORY (Have you been diagnosed with any of the following in the past year?)

Cataract Surgery (Date of Surgery) Right Left

Retina Surgery (Date of Surgery) Right Left

Explanation of Eye Injury: Right Left

Yes	No	
☐	☐	Cornea Disease
☐	☐	Glaucoma
☐	☐	Injury
☐	☐	Cataracts
☐	☐	Retina Disease
☐	☐	Crossed Eyes
☐	☐	Iris
☐	☐	Other Eye Disorders

YOUR SURGERY HISTORY (Please include Date & Type)

FAMILY HISTORY (Has anyone in your family (blood relative) had any of the following?
(RELATION TO PATIENT) F - Father M - Mother S - Sister B - Brother
GF - Grandfather GM - Grandmother U - Uncle A - Aunt

Yes	No		Yes	No	
☐	☐	Glaucoma	☐	☐	Diabetes IDDM/Type II
☐	☐	Cataracts	☐	☐	Heart
☐	☐	Cornea Disease	☐	☐	Diabetic Retinopathy
☐	☐	Macular Degeneration	☐	☐	Retinal Detachment
☐	☐	Retinitis Pigmentoso	☐	☐	Stroke
☐	☐	Other Eye Problems	☐	☐	Cancer

Tech Signature _____ Date _____

Patient Name _____ Date _____

Mehan Eye

Maneesh K. Mehan, M.D.
Cornea Specialist
1020 Woodman Dr., Ste 200
Dayton, Ohio 45432
937-258-4570
937-258-4573 (fax)
www.mehaneye.com

I acknowledge that I have received a copy of the PRIVACY POLICIES of Mehan Eye.

_____ ____/____/____
Patient Signature Date

Authorization for Telephone Contact

Due to the number of patients who have voicemail and/or answering machines, we need information about how to communicate with you.

DO YOU HAVE AN ANSWERING MACHINE AT HOME? ☐ YES ☐ NO

IF YES, MAY WE LEAVE A MESSAGE REGUARDING TEST RESULTS, APPOINTMENTS, SURGERY SCHEDULING AND/OR BILLING MATTERS?

PHONE # _____ ☐ YES ☐ NO

DO YOU HAVE VOICEMAIL AT YOUR JOB? ☐ YES ☐ NO

IF YES, MAY WE LEAVE A MESSAGE FOR YOU TO RETURN OUR CALL?

PHONE # _____ ☐ YES ☐ NO

IF YOU ARE NOT AVAILABLE, MAY WE LEAVE THE ABOVE INFORMATION WITH A SPOUSE, RELATIVE OR ANOTHER PERSON? ☐ YES ☐ NO

IF YES. PLEASE STATE THE NAME AND PHONE NUMBER BELOW

SPOUSE _____ PHONE# _____

OTHER _____ PHONE# _____

OTHER _____ PHONE# _____

_____ ____/____/____
Patient Signature Date

WE APPRECIATE THE OPPORTUNITY OF SERVING YOU.

WE PLEDGE TO GIVE YOU OUR VERY BEST MEDICAL CARE.

OFFICE POLICY ON PAYMENT:

It is our policy to require payment of all office charges at the time they are given, unless prior arrangements have been specifically made. All accounts over 60 days will be charged an interest rate of 1.5 percent per month (18% per annum) or a $2.00 minimum. In the event any balance hereunder is not paid as agreed, the undersigned jointly and severally agree to pay all cost charged by the collection company, which costs will not exceed 20% of said unpaid balance, including a reasonable attorneys fee.

INSURANCE POLICY:

Insurance provides for your reimbursement on allowed medical charges. As a courtesy to you we will provide an itemized statement you may send to your insurance company for payment. We will be happy to submit to most insurance carriers, if you have provided us with policy numbers, address, place of employment and any other pertinent information, **You are responsible for all deductibles and charges not covered by insurance. If we/you find we are not in-network with your insurance company, you will be responsible for the balance of the visit.** Please understand that we cannot, as a third party, become involved in prolonged insurance negotiations, this is your responsibility. Please check with your insurance provider to verify eligibility.

I authorize the release of any medical information necessary to process any claim. I permit a copy of the authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

AUTHORIZED FOR RELEASE OF MEDICAL RECORDS:

I authorize the Doctor to release any medical information including diagnosis, x-rays, test results, reports and records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used for any of the following purposes:
diagnosis, insurance, legal, and at times when Doctor deems it necessary in order to ensure the best medical care on my behalf. I further understand that any person(s) that receive these medical records will not release any of the medical information obtained by this authorization to any other person or organization without a further authorization signed by me for release of the information.

I have read the above and accept financial responsibility in full for this account.

SIGNED: _____ DATE: _____

Patient, Parent, or Guardian

IN CASE OF EMERGENCY PLEASE CONTACT:

NAME: _____

PHONE NUMBER: _____ RELATIONSHIP: _____

ADDRESS: _____