PATIENT INFORMATION

PATIENT NAME: _____

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: _____

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: _____

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

We would like to inform our new patients that you will most likely be dilated at this first visit.

Information regarding dilating eye drops.

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist/optometrist to get a better view of the inside of the eye.

Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it is best if you make arrangement not to drive yourself.

Adverse reaction such as acute-closure glaucoma, may be triggered from the diluting drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize Dr. Mehan/Dr. Boroff and/or such assistant as may be designated by him to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

Patient (or person authorized to sign for patient)

_____

Date: _____/_____/_____/

Witness:

_____

Date: _____/_____/_____/

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information

2. OUR LEGAL DUTY

Law Requires Us To:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.

We Have The Right To:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep including information previously created or received before the changes.

Notice Of Change To Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us at the address provided at the end of this notice.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, license and credentials we need to serve you.

ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your medical information for treatment, payment and health care operations, we may use and disclose medical information for the following purposes.

Facility Directory: Unless you notify us that you object, the following medical information about you will be placed in our facility directories: your condition described in general terms.

Notification: We may use and disclose medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. We will share only health information that is directly necessary for your health care, according to our professional judgement. We will also use our professional judgement to make decisions in our best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

Disaster Relief: We may share medical information with a public or private organization or person who can legally assist in-disaster relief efforts.

Fund-raising: We may provide medical information to one of our affiliated fund-raising foundations to contact you for fund-raising purposes. We will limit our use and sharing to information that describes you in general, not personal, terms and the dates of your health care. In any fund-raising materials, we will provide you a description of how you may choose not to receive future fund-raising communication.

Research in Limited Circumstances: We may use medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Funeral Director, Coroner, Medical Examiner: We may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Functions: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and government programs providing public benefits.

Courts Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court or administrative orders, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling diseases, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, To enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence: We may use and disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being a part of a crime or has escaped from legal custody.

Workers Compensation: We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.
Health Oversight Activities: We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

Appointment Reminders: We may use and disclose medical information for purposes of sending you appointment postcards or otherwise reminding you of your appointments.

Alternative and Additional Medical Services: We may use and disclose medical information to furnish you with information about health-related benefits and services that may be of interest to you, and to describe or recommend treatment alternatives.

4. YOU INDIVIDUAL RIGHTS

You Have a Right to:
1. Look at or get copies of certain parts of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact information listed at the end of this notice. If you request copies, we will charge you for postage if you want the copies mailed to you. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to the contact person listed at the end of this notice.
5. Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the contact person listed at the end of this notice.

If you have any questions about this notice or if you think that we may have violated your privacy right, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services by visiting their website @ www.hhs.gov You may contact us to submit a complaint or submit request involving any of your rights in Section 4 of this notice.

We will not retaliate in any way if you choose to file a complaint.