ORLICK, BERGER, KASPER & PATEL, M.D., P.A.
VITREORETINAL DISEASES AND SURGERY

Martin E. Orlick, M.D., FACS
Todd A. Berger, M.D., FACS
Jeffrey I. Kasper, M.D.
Nandesh N. Patel, M.D., FACS

WELCOME TO OUR PRACTICE
PLEASE COMPLETE THE ENCLOSED FORMS AND BRING THEM TO THE OFFICE THE DAY OF YOUR APPOINTMENT.
IF YOU DO NOT BRING COMPLETED FORMS YOU NEED TO ARRIVE 15 MINUTES PRIOR TO YOUR APPOINTMENT TO COMPLETE THEM IN THE OFFICE.

YOUR EYES WILL BE DILATED
IF YOU ARE NOT COMFORTABLE DRIVING DILATED, BRING A DRIVER OR OTHERWISE ARRANGE TRANSPORTATION. DARK GLASSES ARE AVAILABLE SHOULD YOU NEED THEM WHEN YOU LEAVE.

- **PLAN ON YOUR VISIT BEING AT LEAST 2 HOURS LONG.**
- **BRING A LIST OF ANY MEDICATIONS YOU ARE TAKING, INCLUDING VITAMINS**
- **PLEASE BRING YOUR INSURANCE CARDS AND DRIVER'S LICENSE/PHOTO ID WITH YOU**

NOTE: WE DO NOT DISPENSE GLASSES OR CONTACTS

Thank you!

5800 - 49th Street N., Suite S-109 | St. Petersburg, Florida 33709
(727) 522-1115 | Fax (727) 522-0018 | www.orlick-berger-kasper.com

MEDICAL HISTORY QUESTIONNAIRE

Patient Name_____ DOB:_____

PAST MEDICAL/SURGICAL HISTORY - *Have you had or do you have...*

Abnormal Blood Pressure	Yes	No	Epilepsy	Yes	No	Pregnant now	Yes	No
AIDS/HIV+	Yes	No	Heart Disease	Yes	No	Prolonged bleeding	Yes	No
Anemia	Yes	No	Hepatitis	Yes	No	Stroke	Yes	No
Arthritis	Yes	No	Kidney Disease	Yes	No	Thyroid Disease	Yes	No
Artificial Heart Valves	Yes	No	Liver Disease	Yes	No	Tuberculosis	Yes	No
Asthma/COPD	Yes	No	Organ Transplant	Yes	No	Ulcers	Yes	No
Cancer	Yes	No	Osteoporosis	Yes	No	Venereal Disease	Yes	No
Diabetes	Yes	No	Pacemaker	Yes	No			

Other illnesses: _____

Prior non-eye surgeries: _____

REVIEW OF SYSTEMS – *do you have any current problems in the following areas?*

General: ☐ none ☐ weight change ☐ fatigue ☐ fever/chills

Ears, Nose, Throat: ☐ none ☐ difficulty hearing ☐ Sinus disease ☐ sore throat

Cardiovascular: ☐ none ☐ chest pain ☐ palpitations ☐ murmur

Respiratory: ☐ none ☐ shortness of breath ☐ cough ☐ wheezing

Gastrointestinal: ☐ none ☐ nausea/vomiting ☐ belly pain ☐ blood in stool

Bladder/Kidney: ☐ none ☐ blood in urine ☐ painful urination

Muscles/Bones: ☐ none ☐ joint pain/stiffness ☐ back pain ☐ muscle aches

Skin: ☐ none ☐ rash ☐ itching ☐ cancerous lesions

Endocrine: ☐ none ☐ heat/cold intolerance ☐ excessive thirst

Blood/Lymph: ☐ none ☐ easy bruising/bleeding ☐ swollen glands

Allergy/Immuno: ☐ none ☐ hives ☐ hayfever ☐ frequent infections

Neurologic: ☐ none ☐ numbness/weakness ☐ dizziness ☐ headaches

Psychiatric: ☐ none ☐ anxiety/depression ☐ memory loss

CURRENT MEDICATIONS:
(please list)

ALLERGIES:

Allergic to Iodine? Y N

Allergic to Shellfish? Y N

Medications? Y N
(please list)

PAST OCULAR HISTORY

Eye Diseases:_____

_____

Eye Surgeries: _____

Eye Injury? Y N Eye Infections? Y N Contact Lens? Y N

Last Eye Exam:_____

FAMILY HISTORY

Diabetes? Y N

Glaucoma? Y N

Macular Degeneration? Y N

Retinal tears/detachment? Y N

Other Eye disease? Y N

SOCIAL HISTORY

Tobacco? Y N *How much:*_____ *Years:*____ Alcohol? Y N *How much:*_____

Occupation _____ Marital Status: _____ Living: *Alone* *Nursing home* *ALF* *Shelter*

Is anyone in your immediate family seeing a physician in our practice?

Signature of Patient or Representative_____ Date_____

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NEW PATIENT REGISTRATION/INFORMATION FORM

DATE_____ **Patient ID#**_____

Referring Doctor: _____ **Phone:** (____) _____

Family Physician: _____

Patient name:_____
First *Middle* *Last*

Patient address:_____
Street *Suite/Apt*

_____
City *State* *Zip*

Patient email address:_____

Is this address a skilled Nursing Facility, Rehabilitation Facility, Nursing Home or other Medical Facility? Yes No

Home phone: (____) _____ **Cell phone:** (____) _____

Date of Birth: ____/____/____ **SS#**____-____-____
MUST INCLUDE MUST INCLUDE

Ethnicity: Hispanic Non-Hispanic Decline **Sex: M F**

Race: White, Black, Asian, American Indian/Alaskan Native, Pacific Islander, Other, Decline

Preferred Language: _____

Marital Status: Single Married Separated Divorced Widowed Partner

Parent/Guardian/Care Giver Name:_____

Phone: (____) _____ **Address:**_____

Do you have insurance coverage? No Yes *(Please present cards/Driver's License)*

Occupation:_____ **Driver's License #**_____

Employer:_____ **Work phone:** (____) _____

Spouse's name:_____ **Phone:** (____) _____

Emergency contact/Relationship:_____
Phone: (____) _____

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FINANCIAL POLICY

All patients need to present their insurance card(s), driver's license or photo identification card at the time of their initial visit. The information will be verified on subsequent visits. Please contact us whenever your information needs to be updated. We will copy and return the cards to you. Your privacy will be held in the strictest of confidence (Please see our Notice of Privacy Practices in the office).

INSURANCE AND MEDICARE PATIENTS

If you have insurance or are covered by Medicare, we will process your claim (except those with addresses out of the United States). **We request that you pay your estimated portion of the charges when services are rendered. Estimated patient responsibility is expected to be paid at the time of service. Any deductible that has not yet been met and your co-payment is due at the time of service.**

If your medical plan requires a referral or an authorization number and you or your referring physician fail to obtain one, you will become responsible for all services provided. If you have commercial insurance and they do not respond within 60 days, payment for services becomes your responsibility.

WORKERS COMP PATIENTS

If you have an injury covered by Workers Compensation, we require that you complete our Workers Comp Information Sheet. If Workers Compensation does not cover your injury, you are responsible for all services provided to you. There is a separate charge for completion of any disability forms or related paperwork and this charge may be the responsibility of the patient.

PRIVATE PAY PATIENTS

As a private pay patient, you are expected to pay at the time of service. A reasonable estimate will be provided, however, the exact costs of services will not be known until the examination is complete. Please ask to see a Financial Counselor if prior arrangements need to be made.

ALL PATIENTS

There is a $20 Service Charge for all resubmitted or returned checks. We will make all reasonable accommodation to collect a balance due from you. If your account is assigned to a collection agency because of non-payment, you will be charged any fees incurred by us through the collection agency up to and including any legal fees necessary to collect the outstanding balance.

By signing below, I authorize the release of medical information necessary to process my claims and I authorize payment to be made directly to Orlick, Berger, Kasper & Patel, M.D.,P.A.

Patient Signature_____ Date_____
(Guardian for Minor)

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NOTICE OF PRIVACY PRACTICES

This notice summarizes how medical information about you may be used and disclosed. The complete Notice of Privacy Practices of Orlick, Berger, Kasper & Patel, M.D., P.A. is available in the waiting room for your review.

Orlick, Berger, Kasper & Patel, M.D., P.A. will use your medical information for the following:

1. TREATMENT: Including providing your medical records to consulting clinicians and insurance companies.
2. PAYMENT: We will file necessary claims to insurance companies in your name to obtain payment. They may request part or all of your medical record to pay the claim.
3. HEALTH CARE OPTIONS: Any others involved in your healthcare.

To protect your privacy and in conjunction with our policy please provide us with the following information and authorizations:

1. Name of person or persons we may speak to regarding your health (ie. Spouse, child, etc. including phone number)

   _____

   _____

   _____

2. May we leave a message regarding your health or an upcoming appointment on your answering machine? YES __ NO __

3. I authorize the release of protected health information to my insurance company if applicable, to the extent necessary to obtain payment for services rendered.

4. I acknowledge that I have the opportunity to review a copy of Orlick, Berger & Kasper, M.D., P.A.'s Notice of Privacy Practices with effective date of 4/14/03. Such copy being available in the waiting room.

Patient Signature _____ Date: _____
Date of Birth: _____
Witness: _____

HIPPAA

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AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Patient name _____ Guardian or Authorized Party name (if applicable) _____

Date of Birth _____ Date of Request _____

I authorize the use and disclosure of the following health information:

_____Records relating to treatment dates from:_____ to_____

_____Records for all care at this facility or by this doctor

_____Other please specify_____

Information to be released: ( ) **FROM** ( ) **TO** _____

_____

_____

( ) **FROM** ( ) **TO** **Orlick, Berger, Kasper & Patel, MD, PA**
5800 - 49th St. N., Suite S-109
St. Petersburg, FL 33709
PH: (727) 522-1115 FAX: (727) 522-0018

I understand: A: I have the right to revoke this authorization in writing, at any time except (1) where uses or disclosures have already been made based upon my original permission or (2) the authorization was obtained as a condition of securing insurance coverage and the insurer by law has the right to contest a claim or the insurance policy B: that uses and disclosures already made based upon my original permission can not be taken back C: that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and no longer protected by the Federal Privacy Standards D: that Orlick, Berger, Kasper & Patel, M.D., P.A. may not condition treatment on my signing this authorization and I have a right to refuse to sign this authorization.

_____ _____

Signature of patient or guardian** Date

A fax copy or photocopy of this consent shall be as valid as the original.

**If this authorization is signed by an individual's personal representative, the representative's authority is based on:_____(e.g. state law, court order, etc.)

FEE SCHEDULE State and Federal laws specify a reasonable fee may be charged to offset the cost associated with reproduction of records. The fee is $1.00 per page for the first 25 pages and $.25 for each additional page. Additional fees apply for copies of fundus photos, fluorescein angiograms, etc.
For Office use only: Physician authorization _____Date sent:_____ By:_____

RECORDS RELEASE