PATIENT INFORMATION FORM
Fante Eye & Face Centre

Patient Name _____

Mailing Address _____

City _____ State _____ Zip Code _____

Telephone: Home _____ Work _____ Cell/Pager _____

Email address: _____Employer _____ Occupation _____

Date of Birth _____ SS# _____ Gender ☐ F ☐ M

Marital Status ☐ Single ☐ Married ☐ Partner ☐ Divorced ☐ Widowed ☐ Other _____

Spouse's Name _____ Work Phone _____

Parents' Names (if child) _____Work Phone _____

Pharmacy _____ Phone_____ Address_____

INSURANCE INFORMATION

Primary Insurance _____

Subscriber Name _____ Date of Birth _____

Secondary Insurance _____

Subscriber Name _____ Date of Birth _____

Are you currently employed? Y N Is your spouse or other family member employed? Y N

Have you ever served in the military? Y N Are you here for an injury from work? Y N

Do you have secondary insurance? Y N Are you covered under any other healthcare plan? Y N

Are your injuries accident related? Y N Are you covered under an employer? Y N

REFERRAL INFORMATION

Who sent you to our office? _____Reason for appt _____

PHYSICIAN INFORMATION

General Doctor _____ Telephone _____

Ophthalmologist _____ M.D. Telephone _____

Optometrist _____ O.D. Telephone _____

Other Specialist Doctors (cardiology, endocrine, cancer, plastic surgery, etc):

Name _____ Specialty _____ Telephone _____

Name _____ Specialty _____ Telephone _____

EMERGENCY INFORMATION

Person to Notify _____

Relationship to you _____Telephone _____

Confidential Medical History Form

Fante Eye & Face Centre

PATIENT NAME: _____ DATE: _____

1. Please list all <u>medications</u> you take on a regular basis:

(Please include any eye drops, vitamins, herbs, or over the counter products such as aspirin or aspirin containing products.)

Medication	Strength	Frequency
1.		
2.		
3.		
4.		
5.		
6.		

2. Please list all <u>illnesses/diseases</u> which you have had or have now:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

3. Please list all prior <u>surgeries or procedures</u>:

Surgery	Physician	Approximate Date
1.		
2.		
3.		
4.		
5.		

4. Please list any <u>allergy or sensitivity</u> to medication or food:

Medication	Reaction
1.	
2.	
3.	

Patient Name:

5. Has anyone in your family had the same problem that brings you to our office?
[ ] Yes [ ] No If yes, who? _____

Do any of these diseases run in your family. If YES, please note relationship

__Glaucoma _____
__Diabetes _____
__High blood pressure _____
__Skin cancer _____
__Other _____

Do you smoke? If YES, how much?
_____

Drink alcohol? If YES, how much?
_____

6. Do any of the following problems apply to you? If YES, please explain.

Constitutional (fever, weight loss, poor appetite, etc.)	☐ yes ☐ no	
Eyes (glaucoma, cataract, lazy eye, retina problems, etc)	☐ yes ☐ no	
Ear/Nose/Throat (hearing loss, sinus problems, sore throat, frequent bloody noses, etc)	☐ yes ☐ no	
Cardiovasc (heart problems, chest pain, high blood pressure, stroke, pacemaker, heart surgery)	☐ yes ☐ no	
Respiratory (asthma, shortness of breath, wheezing, coughing, etc)	☐ yes ☐ no	
Gastro-intestinal (heartburn, diarrhea, vomiting, abdominal pain, etc)	☐ yes ☐ no	
Genito-urinary (urinary problems, blood in urine, etc)	☐ yes ☐ no	
Skin (skin rashes, excessive dryness, used accutane, skin cancer/diseases, etc)	☐ yes ☐ no	
Musculoskeletal (muscle aches, joint pain, swollen joints, artificial joint, arthritis, etc)	☐ yes ☐ no	
Neurological (numbness, weakness, paralysis, headaches, spasm, MS, etc)	☐ yes ☐ no	
Hematologic (blood disorders, leukemia, easy bleeding/bruising, take aspirin, etc)	☐ yes ☐ no	
Allergy (hay fever, seasonal allergies, etc)	☐ yes ☐ no	
Endocrine (thyroid or pituitary problems, etc)	☐ yes ☐ no	
Psychiatric (depression, anxiety, etc)	☐ yes ☐ no	
Hepatitis B or C, HIV or AIDS, Tuberculosis, etc	☐ yes ☐ no	
Diabetes, radiation treatments, anesthesia problems, etc.	☐ yes ☐ no	

Other Comments:_____

_____

Physician Initials _____ Date _____

Fante Eye & Face Centre
3900 E Mexico Avenue
Suite 510
Denver, CO 80210

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding in health information. I understand that this information can and will be used to:

-Conduct, plan and direct my treatment and follow up among the multiple health care providers who may be involved in that treatment directly and indirectly.

-Obtain payment form third party payers.

-Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, and read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures if my heath information. I understand that this organization has the right to charge its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

FOR OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date: _____

Initials: _____

Reason: _____

FANTE EYE & FACE CENTRE
3900 E Mexico Ave • Suite 510
Denver, CO 80210

Financial Policies

Payment is expected at the time of service for all non-contracted fees. Arrangements must be made with our office manager prior to seeing the physician if an account balance is anticipated. I understand that I am financially responsible for all charges whether or not covered by insurance.

Private Insurance

All private health insurance plans represent a contract between you and the insurance company. These contracts are not between the physician and the insurance company. As a courtesy, we will bill your insurance for all services rendered, but we are not responsible if your insurance does not pay. Instead, it is your responsibility to make certain that your insurance makes prompt payment, and to handle any disputes or questions that may arise.

____ ***(initial)*** **If you have not yet met your deductible, there is a $500 deposit due upon scheduling surgery.**

Insurance Contracts

If we participate with your insurance carrier, we will accept assignment on all covered services and bill your insurance for you. You are responsible for the copay, deductible, and all non-covered services. Depending upon your particular benefits package with your insurance, they may cover some, all, or none of the services rendered to you.
Therefore it is your responsibility to:

1. Provide documentation of your coverage
2. Know what benefits are covered by your insurance and what services are your personal responsibilities.
3. Provide the appropriate documents (e.g. referrals) that allow us to bill your insurance carrier. If the appropriate information is not received, you will be asked to sign a waiver of responsibility.

Medicare

We accept Medicare assignment, which means that we accept the allowable charges set by Medicare. Medicare typically pays 80% of the allowable charge after your deductible has been met. You will be responsible for the 20% remainder unless you have a Medicare supplement. We will bill your Medicare supplement after Medicare has paid, if you provide the necessary information to us.

Cosmetic Revisions

Rarely, after complete healing from surgery for which insurance has paid, you and your surgeon may agree that some revision procedure would enhance your cosmetic outcome. I understand that aesthetic surgery is not a covered benefit of Medicare and other insurance carriers. Therefore any aesthetic procedure will be my financial responsibility and payment in full will be expected prior to the procedure.

Medical Authorization Release

By signing below, you authorize Robert G. Fante,M.D. or Michael J. Hawes, M.D. to give you reasonable and proper medical care by today's standard.

I agree that the attending physician may use, or permit other persons to use any negatives, prints, movies, and digital images, and/or other visual or audio recordings, for purposes including, but not limited to, dissemination to health care professionals and/or members of the public for treatment, research, medical, scientific, teaching, or other purposes in such a manner as may be deemed appropriate by my attending physician. I agree that this information may be disseminated in either paper form or digital form using delivery techniques that include but are not limited to the U.S. Postal Service, Federal Express, UPS, email, the Internet, and file transfer protocol.

I hereby authorize Robert G. Fante, M.D. or Michael J. Hawes, M.D. to release any medical or other necessary information to insurance carriers in either paper or digital from concerning this illness/accident. I hereby irrevocably assign all payments for all services rendered to Dr. Robert Fante or Dr. Michael Hawes. I also request payment of government benefits either to myself or to Robert G. Fante, M.D. or Michael J. Hawes, M.D. I have read and understand the policies described above. I have provided complete and accurate medical and financial information on all forms. I acknowledge that I am responsible to pay all charges for treatment as outlined above.

A copy of this authorization shall be considered valid as the original.

_____

Patient Signature/Responsible party Date