Potomac Ophthalmology

Maureen O'Dea, M.D.

Date: _____

Name (Last, First, M.I.): _____

Home Address: _____
Street City State Zip

Home Phone: (_____) _____ **Work Phone:** (_____) _____

Cell Phone: (_____) _____ **Date of Birth:** _____ **Age:** _____

Marital Status: S M D W **Sex:** Male Female **SSN:** _____

Preferred Pharmacy: _____ **Pharmacy Address:** _____

Employer: _____ **Occupation:** _____

Work Address: _____

Contact: (Circle Applicable) Emergency Contact Next of Kin Insured

Name: _____ **Relationship to Patient:** _____

Date of Birth: _____ **Sex:** Male Female **SSN:** _____

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

Referring Physician: _____ **Office No.** (_____) _____

Office Address: _____

Family Physician: _____ **Office No.** (_____) _____

Office Address: _____

Financially Responsible Party

Guarantor Name: _____ **Date of Birth:** _____ **Relationship:** _____

Address: _____

Home Phone: (_____) _____ **Cell Phone:** (_____) _____

Insurance Policy Information

Primary Insurance: _____

ID Number: _____ **Group Number:** _____

Claims Mailing Address: _____

Secondary Insurance: _____

ID Number: _____ **Group Number:** _____

Claims Mailing Address: _____

Work Injury?

Date of Injury: _____ **Claim Number:** _____

Claims Mailing Address: _____

Phone No. (_____) _____ **Person Handling Claims:** _____

ASSIGNMENT OF BENEFITS

I, _____, hereby assign all medical/ surgical benefits, to include Medicare, Medical Assistance of DC/MD, Blue Shield of MD/NCA, private insurance and other health plan to Maureen T. O'Dea, M.D. and request that the payments for services rendered be made directly to Maureen T. O'Dea, M.D.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or the above named carrier, at any time in writing.

I UNDERSTAND, I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT COVERED BY INSURANCE. Insurance is considered a method of reimbursement and is not a substitute for payment. Payment is expected at time of service unless arrangements have been made with the office in advance. Some insurance companies have fixed amounts for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible, co-insurance, or non-allowed charges. Should your account be sent to collections for non-payment, you will be responsible for all collection and attorney fees that may be incurred.

If a referral is required for your office visit or service, it is your responsibility to ensure that we have a valid referral at our office *before* you see the doctor. We cannot call your primary physician and wait until a referral is "faxed" or mailed.

I hereby authorize the release of any medical information necessary to process the insurance claims. I am also aware of the referral policy.

I will provide the office with my most current insurance information.

Patient Signature: _____ Date: _____

MEDICAL HISTORY

Name Date

Date of last eye exam: _____

List any medications you are currently take (Rx and over-the-counter):

_____

Do you have allergies to any medications? YES NO

If **YES**, list the medications: _____

List all major illnesses (glaucoma, diabetes, high blood pressure, heart attack, etc.) or injuries (concussion, etc.):

_____

List any surgeries you have had (cataract, appendectomy):

Do you currently have any problems in the following areas? If **YES**, please provide additional information.

	YES	NO	Details
EYES (poor vision, eye pain, tearing, redness, etc.)			
GENERAL /CONSTITUTIONAL (fever, heat stroke, weight loss, weight gain, unusually tired)			
EAR, NOSE, THROAT (hard of hearing, stuffy nose, earache, cough, dry mouth, etc.)			
CARDIOVASCULAR (high BP, racing pulse, etc.)			
RESPIRATORY (congestion, wheezing, short of breath, etc.)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)			
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, yellow jaundice, etc.)			
FEMALES Are you pregnant? Nursing?			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
SKIN (pimples, warts, growths, rash, etc.)			
NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDROCRINE (diabetes, hypothyroid, etc.)			
BLOOD / LYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)			
ALLERGIC / IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)			

FAMILY HISTORY

(Mother, Father, Grandparents, Sibling)

Have any members of your family had these diseases? (circle all that apply) YES NO UNKNOWN

Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis

Other heritable disease:

SOCIAL HISTORY

Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)? YES NO

Have you had a blood transfusion? YES NO

Do you drink alcohol? YES NO If YES, how much? _____

Do you smoke? YES NO If YES, how much? _____ How many years? _____

Physician's Signature: _____ Date: _____

POTOMAC OPHTHALMOGY

2296 Opitz Blvd, Suite 410 Woodbridge, VA 22191
(703) 580-5348

Maureen T. O'Dea, M.D.

Ophthalmologist, Eye Physician and Surgeon
Certified by the American Board of Ophthalmology

TO OUR PATIENTS

IMPORTANT PAYMENT INFORMATION

REFRACTIONS

Refraction is the process of determining the eye's refractive error, or need for glasses and/or contact lenses. It is an essential part of an eye examination, but it is considered a non-covered service by Medicare and most insurance companies; thus, it becomes the responsibility of the patient to pay for the refraction portion of the examination. Our office fee for a refraction is $50.00, and this fee is collected at the time of your visit in addition to any co-payments.

I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service. The co-payment is separate from and not included in the refraction fee.

Patient Signature (Parent if Minor) Date

Printed Name

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Maureen T. O'Dea, M.D.
Ophthalmologist, Eye Physician and Surgeon
Certified by the American Board of Ophthalmology

Acknowledgement of Receipt of Notice of Privacy Practices

By my signature below, I acknowledge that I have received the Notice of Privacy Practices of Potomac Ophthalmology (Dr. Maureen T. O'Dea, M.D.)

Printed Name: _____

Signature: _____ Date: _____