THE RETINA CENTER

Edward J. Goldman, MD PA

FILL IN ALL THE BLANKS
NEW PATIENT INFORMATION (PLEASE PRINT)

Date: _____

PATIENT LAST NAME	PATIENT FIRST NAME	DATE OF BIRTH
STREET ADDRESS	CITY & STATE	ZIP CODE
HOME PHONE #	ALTERNATE PHONE #	SS#
REFERRING PHYSICIAN	PHYSICIANS ADDRESS	PHONE #
FAMILY PHYSICIAN	PHYSICIANS ADDRESS	PHONE #
CARDIOLOGIST/OTHER - SPECIFY	PHYSICIANS ADDRESS	PHONE #

PERSON RESPONSIBLE FOR PAYMENT	ADDRESS	PHONE #

EMAIL ADDRESS: _____

In case we need to reach you and you are not at home, please provide us with a name and phone number of a friend or relative.

EMERGENCY CONTACT	RELATIONSHIP	PHONE #

PRIMARY INSURANCE	POLICYHOLDER	POLICYHOLDER BIRTHDATE
ID #	GROUP #	

SECONDARY INSURANCE	POLICYHOLDER	POLICYHOLDER BIRTHDATE
ID #	GROUP #	

EMPLOYER	OCCUPATION	BUSINESS PHONE #
EMPLOYER ADDRESS	CITY & STATE	ZIP CODE

I hereby authorize Edward J. Goldman, M.D., P.A., t/a The Retina Center, and Dr. Edward Goldman to furnish all requested information to the patient's insurance carrier(s) concerning the illness being treated and any treatment being rendered by Dr. Goldman to the patient. I do further assign to the aforesaid all payments for medical services rendered by Dr. Goldman to the patient. If there is no insurance coverage, or if the patient's insurance carrier otherwise fails to pay for the services rendered (e.g., for non-covered services, deductible, co-insurance, co-pays, etc.), I accept full responsibility for any balance and will remit payment promptly to Edward J. Goldman, M.D., P.A., t/a The Retina Center. If I fail to comply with the above, I agree to a late fee equal to ten percent (10%) of any balance not paid within sixty (60) days of the date of final billing, as well as interest at the rate of one percent (1%) per month on any unpaid balance, plus costs of collection, reasonable attorney's fees (that will in no event by less than fifteen percent (15%) of any unpaid balance), and any court costs incurred in addition to these other charges.

Signature: _____ Date: _____

PAST MEDICAL HISTORY 2020

Patient Name: _____ **Date of Birth:** _____

DATE OF LAST FULL PHYSICAL EXAMINATION: _____

MEDICATION ALLERGIES? _____

PREFERRED PHARMACY: _____ *LOCATION:* _____

ARE YOU PREGNANT NOW? ☐ *YES* ☐ *NO*

Check ALL Surgeries that apply:

☐ **Cataract:** Year(s) of Surgery_____(CIRCLE) Right Eye, Left Eye or Both Eyes)

☐ **Heart: (Circle Those That Apply and List Year)**

Bypass _____ Stent _____

Pacemaker _____ Other: _____

☐ **Blood Vessel: (Circle Those That Apply and List Year)**

Carotid _____ Leg _____

Bypass _____ Other: _____

☐ **Skeletal: (Circle Those That Apply and List Year)**

Hip _____ Knee _____

Amputation _____ Other: _____

☐ **General: (Circle Those That Apply and List Year)**

Gall Bladder_____ Tonsils_____

Hernia_____ Appendix_____

Hysterectomy_____ Other: _____

☐ **Cancer: (Circle Those That Apply and List Year)**

Skin_____ Breast_____

Colon_____ Other: _____

BACK

CHECK (✓) ONLY ALL THAT APPLY:

	DISEASES	DATE OF ONSET	RELEVANT DETAILS
	Diabetes		
	Hypertension		
	Heart Disease:		
	Coronary Artery		
	Valve Disease		
	Rhythm Disturbances		
	Other		
	Stroke		
	Transient Ischemic Attack		
	Cholesterol Disorders		
	Thyroid Disease		
	Arthritis		
	Rheumatoid Arthritis		
	Lupus		
	Other Autoimmune Disease		
	Kidney Disease		
	Kidney Stones		
	Prostate Disease		
	Ulcerative Colitis		
	Crohn's Disease		
	Psoriasis		
	Cancer		
	COPD		
	Parkinson's Disease		
	Seizure Disorder		
	Migraine Headaches		
	Psychiatric Disorder:		
	Depression		
	Anxiety		
	Bipolar Disorder		
	Dementia		
	Alzheimer's Disease		
	ADHD		
	Infectious Disease:		
	Hepatitis		
	Tuberculosis		
	HIV/AIDS		

OTHER: _____

Patient Signature: _____ **Date:** _____

REVIEW OF SYSTEMS QUESTIONNAIRE 2020

Patient Name: _____

GENERAL/CONSTITUTIONAL:

☐Fever ☐Unexplained Weight Loss ☐Fatigue ☐Loss of Appetite ☐None

HENT/EARS, NOSE, THROAT:

☐Hearing Loss ☐Sinus Problems ☐Jaw Pain When Chewing ☐Mouth Sores ☐Scalp Tenderness ☐None

CARDIOVASCULAR:

☐Irregular Heart Beat ☐Chest Pain ☐Shortness of Breath ☐Shortness of Breath when Laying Flat ☐Swelling of Feet ☐None

RESPIRATORY:

☐Long-Term Oxygen Therapy ☐Asthma ☐Wheezing ☐Cough ☐Sleep Apnea ☐None

ENDOCRINE:

☐Excess Thirst ☐Excessive Urination ☐Heat Intolerance ☐Cold Intolerance ☐None

GASTROINTESTINAL:

☐Nausea ☐Acid Reflux ☐Diarrhea ☐Jaundice or Yellow Skin ☐None

GENITOURINARY:

☐Genital Sores or Ulcers ☐Difficulty with Urination ☐Pain or Burning on Urination ☐None

INTEGUMENTARY/SKIN:

☐Rash ☐Tick or Insect Bites ☐White Patches of Skin or Hair ☐Painfully Cold Fingers ☐None

MUSCULOSKELETAL:

☐Painful or Swollen Joints ☐Joint Pain ☐Muscle Aches ☐Stiff Lower Back ☐None

NEUROLOGIC:

☐Frequent or Severe Headaches ☐Numbness or Tingling in Body ☐Weakness ☐Dizziness ☐Tremor ☐Speech Problems ☐None

HEMATOLOGY/ONCOLOGY:

☐Easy Bruising ☐Prolonged Bleeding ☐None

ALLERGY/IMMUNOLOGY:

☐Environmental Allergies ☐Seasonal Allergies ☐Chronic Allergies ☐None

PSYCHIATRIC:

☐Anxiety ☐Depression ☐Loss of Memory ☐None

Patient Signature : _____ **Date :** _____

Patient Name : _____

INSTRUCTIONS:

1. List names of ALL ORAL and INJECTABLE medications AND the DOSAGE you are taking to include any eye drops.

MEDICATIONS	DOSAGE

Patient Signature: _____ Date: _____

HIPAA Privacy
Acknowledgment of Receipt of Privacy Notice

By signing this acknowledgment of Receipt of Notice of Privacy Practices revised September 21, 2013. I acknowledge and agree that I have read and can receive a copy of the Notice of Privacy Practices for review and to keep for my records on the date identified below.

Patient agrees to release of medical or other information to process claim

Patient agrees to accept assignment of payment

Patient gave office the permission to leave a message on their answering machine

Patient gave permission to discuss their medical condition with another person unless otherwise specified below

_____

Signature: _____ Date: _____

Notice Effective Date: September 21, 2013

EDWARD J. GOLDMAN, MD PA/ THE RETINA CENTER
FINANCIAL POLICY

We are committed to providing you with the best possible care, and we are available to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

REFERRALS: Some managed care plans require written referrals or authorizations for office visits, surgery or injections. We will do our best to obtain this information but may need your assistance if referral is not received by the time of your visit.

INSURANCE: Insurance is a contract between YOU and YOUR INSURANCE COMPANY. We will submit claims to your carrier on your behalf however; you will be responsible for any deductibles, co-payments and co-insurances. If you are a self-pay patient, payment is due at the time of service.

CO-PAYMENTS/CO-INSURANCES/DEDUCTIBLES: All co-payments and co-insurances are due at the time services are rendered. If you have questions regarding your co-payment or co-insurance amount, please contact your insurance carrier. If full payment of co-insurances will be a hardship, please contact our billing department to discuss payment arrangement.

RETURNED CHECKS: A $50.00 processing fee will be applied to all returned checks.

WE ACCEPT CASH, CHECKS, CREDIT CARDS AND MONEY ORDERS.
(Visa, MasterCard and Discover)

We would like to thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I authorize the release of any medical information necessary to process my insurance claims. I allow fax transmittal of my medical records, if necessary. I request payment of authorized Medicare/Insurance benefits be made to Edward J Goldman, MD PA/The Retina Center on my behalf, for any services furnished to me by them. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents, or other insurance agencies, any information needed to determine benefits payable for related services.

I understand that I am financially responsible for all charges whether or NOT paid by insurance. If full payment is not made with regard to bills for services rendered, I agree to pay all necessary and reasonable costs of collection of account balance, including but not limited to Attorney's fees of no less than 15% and/or court costs in addition to these other charges. I agree to a late fee equal to 10% of any balance not paid within 60 days of the date of final billing, as well as interest at the rate of 1% per month on any unpaid balance.

I agree to accept all Financial Responsibility for services rendered.

Signature: _____ Date:_____