The MACULA CENTER
Dana M. Deupree, M.D., F.A.C.S.

PATIENT INFORMATION

Chart Number_____

PLEASE PRINT

Today's Date _____

Patient's Name_____
Last Name First Name MI.

Spouse's Name_____

Sex_____ **Birthdate** _____-_____-_____ **SS#** _____-_____-_____
M / F Month Day Year

Permanent Mailing Address _____
Street

City_____ **State**_____ **ZIP** _____ **Home Phone (**_____**)**_____

2nd Address _____ **Email**_____
Street We will not share your email with 3rd parties unless you request it

City_____ **State**_____ **ZIP** _____ **Phone (**_____**)**_____

Employer _____ **Phone (**_____**)**_____

Employer's Address _____

In Case of Emergency

Nearest Relative or Friend/Guardian_____**Phone (**____**)**_____

Relationship to Patient _____

Primary Care Physician_____

Previous History of Eye Treatment or Exams:

_____

_____

_____

_____

Any Family History of Eye Disease or Eye Surgery:

_____

_____

_____

_____

What problems are you having with your eyes?_____

_____

Referred or recommended by_____

Thank you for choosing The Macula Center and Dana M. Deupree, M.D

3280 N McMullen Booth Road, Suite 120 • Clearwater, FL 33761 • (727) 7 89-8770 • FAX (727) 789 -8784 • www.MaculaCenter.com

The Macula Center
Dana M. Deupree, M.D., F.A.C.S.

MEDICAL HISTORY AND REVIEW FORM

FILE NO:_____

NAME:_____ **PHONE:** (____) _____ **TODAY'S DATE:**_____

FAMILY PHYSICIAN:_____ **PHONE:** (____) _____

PHARMACY: NAME:_____ **PHONE:** (____) _____

EMERGENCY CONTACT NAME:_____ **PHONE:** (____) _____

EMAIL ADDRESS:_____

PAST MEDICAL HISTORY: *Please check if YES for each of the following:*

____ Rheumatic Fever
____ Pneumonia
____ Tuberculosis
____ Asthma
____ Emphysema/COPD
____ Cancer
____ High Blood Pressure
____ Bleeding Problems
____ Carotid Artery Disease
____ Thyroid Disease
____ AIDS
____ Migraines
____ High Cholesterol
____ Multiple Sclerosis
____ Sickle Cell Disease

____ Heart Disease
____ Angina
____ Irregular Heartbeat
____ Heart Attack
____ Congestive Heart Failure
____ Stroke
____ Claustrophobia
____ Psychiatric Disorder
____ Alzheimer's
____ Seizures
____ Lyme Disease
____ Radiation/Chemo
____ Meningitis
____ Sleep Apnea
____ Temporal Arteritis

____ Diabetes
____ Liver Disease
____ Hepatitis
____ Kidney Disease
____ Hiatal Hernia
____ Ulcers
____ Phlebitis
____ Anemia
____ Arthritis
____ Diverticulosis
____ Rheumatoid Arthritis
____ Lupus
____ Diabetes Type I/Type II
____ Parkinson's disease
____ Other

____ **AGE**

____ **MALE**
____ **FEMALE**

DATE OF BIRTH:
_____

Have you or a family member been diagnosed with the following? *Check if YES*

____ Creutzfeldt-Jakob Disease
____ Gerstmann-Straussler-Scheinker Disease
____ Fatal Familial Insomnia
____ Have you received hormone injections to increase your height?

HOSPITALIZATIONS/SURGERY: List any previous below:

Surgery	**Date**
Thyroid/Neck	_____
Heart	_____
Lung	_____
Stomach/Abdomen	_____
Cancer	_____
Other	_____

ALLERGIES TO MEDICATIONS:

_____

NO KNOWN ALLERGIES ☐ LATEX SENSITIVITY ☐

SOCIAL HISTORY: Occupation: _____
Do you smoke? **NON-SMOKER EX-SMOKER SMOKER**
Do you drink alcohol? **NONE OCCASION 1-2DAILY 3-4DAILY**
Substance abuse? **NONE IVDA UNKNOWN**
Marital status: **MARRIED SINGLE DIVORCED WIDOWED**

FAMILY HISTORY: *How related*

Diabetes _____ Cancer _____
High Blood Pressure _____ Stroke _____
Heart Disease _____
Ocular Disease – Macular degeneration _____
Glaucoma _____Retinal Detachment_____
Blindness_____
Other _____

***** PRESCRIPTION/NON-PRESCRIPTION MEDS: *****

_____
_____
_____
_____
_____
_____
_____

Review of Systems: Do you have these now? *If YES, explain:*

NO	YES		NO	YES	
___	___	Fever/Weight loss/Fatigue/Loss of appetite_____	___	___	Pain/Burning on urination/Blood in Urine_____
___	___	Hearing Loss/Sore Throat_____	___	___	Rash/Change in Mole_____
___	___	Chest Pain/ Shortness of Breath_____	___	___	Swelling in the Feet_____
___	___	Wheezing/Cough _____	___	___	Muscle Aches/ Joint Pain/ Difficulty Lying Flat_____
___	___	Excess Thirst/Excessive Urination_____	___	___	Headaches/Scalp Tenderness/Tremor_____
___	___	Heat Intolerance/Cold Intolerance_____	___	___	Easy Bruising/Prolonged Bleeding_____
___	___	Abdominal Pain/Nausea_____			

FOR OFFICE USE ONLY: **REFERRING DOCTOR:**

NAME_____ PHONE (_____) _____ ADDRESS:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse To Sign This Acknowledgement

I, _____, have received a copy of
(Print Name)

this Office's Notice of Privacy Practices.

_____
(Please Print Name)

_____
(Signature)

_____
(Date)

For Office Use Only
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

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RECORDS RELEASE AUTHORIZATION

I HEREBY AUTHORIZE AND REQUEST THE RELEASE OF MY COMPLETE MEDICAL RECORD TO BE RELEASED FROM:

_____
Name of Doctor / Hospital / Clinic

_____
Address City State ZIP

_____
Telephone Number

_____
FAX

SEND TO:

_____
Name of Doctor / Hospital/ Clinic

_____
Address City State ZIP

_____
Telephone Number

_____
FAX

Patient Signature X _____ Date _____

PRINT: Patient Name _____ S.S.# _____

Patient Address _____

Telephone _____ Date of Birth _____

Chart Number _____

Witness Signature _____ Date _____

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3280 N. McMullen Booth Rd, Ste 120, Clearwater, FL 33761 727.789.8770

Patient History Update Form

Patient name _____ Chart #_____ Date _____

	No update (✓)	Updated (new) information
Name	_____	_____
Address	_____	_____
Email	_____	_____
Race		White | Hispanic/Latino | Black/African American | Am. Indian Asian or Pacific Islander | Middle Eastern | Hawaiian | Decline
Ethnicity	_____	θ **Of Hispanic origin** θ **NOT of Hispanic origin**
Pharmacy name/address/ph	_____	_____
Past Medical history	_____	_____
Past Surgical history	_____	_____
Smoking	_____	_____
Alcohol consumption	_____	_____
Other drugs	_____	_____
New allergies to meds	_____	_____
Prescription changes	_____	_____

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HIPAA Patient Questionnaire

1. Please list the family members or other person(s), if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations):

Name _____ Phone Number: _____

Name _____ Phone Number: _____

Name _____ Phone Number: _____

Name _____ Phone Number: _____

2. Please list the family members or others, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY.**

Name _____ Phone Number: _____

Name _____ Phone Number: _____

Name _____ Phone Number: _____

Name _____ Phone Number: _____

3. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent ***if other than your home*. (Confidential Communications)**

_____

_____

4. Please indicate if you want all correspondence from our office sent in a sealed envelope marked **"CONFIDENTIAL"**: Yes: ☐ No: ☐

5. Please print the telephone number or email address where you want to receive calls about your appointments, test results or other health care information if other than your home phone number:

Phone: (_____)_____ Email Address: _____@_____

6. Can confidential messages (ie., appointment reminders) be left on your telephone answering machine or voicemail? Yes: _____ No: _____

7. I understand the Privacy Protection Act and have been offered a copy of the Organization's Notice of Privacy Practices updated for the HITECH Omnibus Rule of 2013.

PATIENT NAME: _____ (guardian if under 18 years)

_____ _____

PATIENT/GUARDIAN SIGNATURE DATE DATE

THE MACULA CENTER FINANCIAL POLICY

Thank you for choosing The Macula Center as your health care provider. We are committed to your visit being successful on all levels. Because healthcare reimbursement is a complex and sometimes complicated system, we need your help to ensure your insurance benefits are maximized. The following is a statement of our Financial Policy which you will need to read and sign prior to any services. We also require all patients to give us complete demographic and insurance information prior to or upon arrival at our office.

For patients with insurance coverage, including Medicare

We accept assignment of insurance benefits. We will file a claim with your insurance company for any services you receive. The balance of your account after insurance pays is your responsibility. We cannot bill your insurance company without your insurance information and a copy of your insurance card(s): You are responsible to inform us if you have more than one insurance carrier and which carrier is primary and which is secondary. Your insurance policy is a contract between you and your insurance company. If your insurance company has not paid your account in full within 60 days of the date of service, the balance will be automatically transferred to you.

Each insurance plan has different policies regarding how often services may be rendered and, more importantly, where those services may be performed. Even within the same insurance company, plans can offer different benefits, depending on what your employer has negotiated. We strongly urge you to be familiar with your policy benefits.

Patient Responsibility

All co-pays required by your insurance company must be paid at the time of service. This payment is a requirement by your insurance company. Our office policy allows us to also collect co-insurance, and or deductible amounts at the time of service. All co-insurance and deductible amounts must be paid within 30 days of your insurance payment or determination of benefits from your insurance carrier. If your insurance coverage changes for any reason, it is your responsibility to inform our office and to provide any new insurance information along with a copy of your new card.

For patients with no insurance coverage

If you do not have insurance coverage, payment for services is expected at the time services are rendered.

For patients under Workers' Compensation

We accept assignment of insurance benefits for patients covered under workers' compensation. We will schedule an appointment after being notified from your employer or workers' compensation company. They will provide a claim number and address where to file the claim. The Insurance information and the contact to call to obtain authorization for services is necessary prior to your visit. You are responsible to inform us if your visit is related to a workers' compensation injury.

Patients involved in an automobile or other accident

We accept assignment of insurance benefits for patients involved in an auto accident upon doctor's approval. If it is approved, we will need the claim number, date of accident and address for the claims department before scheduling an appointment. We will file a claim with your auto insurance company for any services you receive. It is your health insurance company's responsibility to subrogate the claim with your auto insurance or any other party responsible for the accident.

We cannot bill the insurance company unless you give us the insurance information and a copy of your insurance card(s). You are responsible to inform us if your visit is related to an auto accident. The balance of your account is your responsibility regardless of payment from your insurance carrier. Your insurance policy is a contract between you and the insurance company. If your insurance company has not paid your account in full within 90 days from the date of service, the balance will be automatically transferred to you. We will not accept assignment from any other third party in relation to an automobile accident.
When all auto benefits are exhausted, we will file claims with your health insurance. If you are not insured, you will be responsible for all charges at the time of service.

Contact Information
Following your visit to the office we will file a claim with your insurance company if you have coverage. After we have received payment from your insurance company you may receive a statement showing any balance due from you. This amount is your responsibility and is due within 30 days of the statement date. We accept cash, checks, Visa, MasterCard, Discover American Express and Care Credit. If you have any questions regarding the balance on your account, please call our business office at 727-789-8770.

_____
Patient name

_____ _____
Signature of Patient or Responsible Party Date

COMMERCIAL INSURANCE
I authorize The Macula Center., to release to my health insurance company, any information needed to determine benefits for services or related services. I permit a copy of this authorization to be used in place of the original. I also request that payment of authorized benefits be made on my behalf to The Macula Center.

_____
Patient name

_____
Chart #

MEDICARE
I authorize The Macula Center to release to Medicare and its agents, any information needed to determine benefits for services or related services. I permit a copy of this authorization to be used in place of the original. I also request that payment of authorized benefits be made on my behalf to The Macula Center.

_____
Patient name

_____
Chart #

MEDIGAP (Medicare Supplemental Policies)
I request payment of authorized Medigap benefits be made on my behalf to The Macula Center, for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release to my Medigap insurer any information needed to determine these benefits.

_____
Patient name

_____
Chart #

Worker's Compensation

I request payment of authorized Worker's Compensation benefits be made on my behalf to The Macula Center for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release to my Worker's Compensation insurer any information needed to determine these benefits.

_____

Patient name

_____

Chart #

AUTO INSURANCE

I authorize The Macula Center., to release to my auto insurance company, any information needed to determine benefits for services or related services. I permit a copy of this authorization to be used in place of the original. I also request that payment of authorized benefits be made on my behalf to The Macula Center.

_____

Patient name

_____

Chart #