PATIENT/GUARANTOR FORM

NAME:_____ DATE OF BIRTH:_____

PREFERRED NAME/NICKNAME: _____

ADDRESS:_____

_____

HOME PHONE NUMBER:_____

CELL PHONE NUMBER:_____

DOES YOUR CELL ACCEPT TEXT MESSAGES: _____YES or NO_____

WORK PHONE NUMBER:_____

EMAIL ADDRESS:_____

RACE:_____ HISPANIC: ____YES or NO____ LANGUAGE:_____

BIRTH SEX:_____ CURRENT GENDER: _____ GENDER IDENTITY: _____

SEXUAL ORIENTATION: _____PREFERRED PRONOUNS: _____

SOCIAL SECURITY:_____

FAMILY DOCTOR:_____

REFERRING DOCTOR:_____

PHARMACY:_____

PARENTAL INFORMATION IF PATIENT IS A MINOR AND/OR INSURANCE POLICY OWNER INFORMATION IF YOU ARE NOT THE INSURED:

NAME:_____ DATE OF BIRTH:_____

ADDRESS:_____

_____

HOME PHONE NUMBER:_____

CELL PHONE NUMBER:_____ ACCEPTS TEXT: YES or NO

SOCIAL SECURITY:_____ RELATIONSHIP TO PATIENT:_____

PATIENT NAME:_____ **BIRTHDATE:**_____

PATIENT BILLING CORRESPONDENCE

INSURANCE AUTHORIZATION AND ASSIGNMENT (PLEASE READ AND SIGN)

I hereby authorize Houser Newman Associates to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amounts not covered by insurance.

Date:_____ Signature:_____

PLEASE READ AND SIGN IF COVERED BY MEDICARE

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Houser Newman Associates for any service furnished to me by that physician(s) or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Date:_____ Signature:_____

Acknowledgment of Receipt of Privacy Notice

I have been presented with a copy of HOUSER NEWMAN ASSOCIATES, MAHONING VALLEY AMBULATORY SURGERY CENTER, and LEHIGH ANESTHESIA ASSOCIATES **Notice of Privacy Policies**. My information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I will allow the following persons to receive my personal medical information:

Name:_____ Relationship to Patient:_____

Name:_____ Relationship to Patient:_____

Name:_____ Relationship to Patient:_____

Name:_____ Relationship to Patient:_____

Name:_____ Relationship to Patient:_____

I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefit apply.

Patient Name:_____ DOB:_____

Patient Signature: _____ Date: _____

If not signed by the patient, please indicate relationship to patient (e.g., spouse)

Relationship: _____ Witnessed by: _____

If patient or patient's representative refuses to sign acknowledgement of receipt notice, please document the date and time the notice was presented to patient and sign below.

Presented on: _____ By: _____

(date/time) (name/title)

HOUSER NEWMAN associates

General Ophthalmology
Donald A. Newman, M.D., F.A.C.S.
Angela G. Houser, M.D.

Optometry
Joseph S. Pancher, O.D.
Cassandra J. Pastier, O.D.

What is the difference between Vision Insurance and Medical Insurance?

Vision Insurance (Vision Plans)

It is important that you understand that your Vision Plan (VSP, Davis Vision, NVA, etc.) covers **ROUTINE** well-eye exams only, which includes the refraction to determine your eyeglass prescription. Your plan may also provide discounts or allowances toward eyeglass frames, lenses, or contact lenses.

As part of a routine well-care exam, our doctors examine your eyes for routine eye health and to determine the need for glasses or other refractive correction. If a medical eye condition is known, or discovered during this exam, a separate exam must then be made to address these issues and will be filed under your medical insurance. If your routine well-eye examination reveals a medical condition or disease which requires special testing or follow-up care, the testing and subsequent examinations will be billed to your medical insurance as these are **NOT COVERED** by your Vision Plan.

It is important to know that if you have a specific eye or vision complaint which is related to a new or pre-existing condition, such as cataract, glaucoma, diabetes, dry eyes, etc. or if you are here for a follow up appointment for a pre-existing condition as requested by a doctor, then your visit is **NOT COVERED** by your Vision Plan and will be billed to your medical insurance. Unfortunately, the doctor cannot always be sure whether a complaint such as decreased vision is related to a medical eye condition until after you are thoroughly examined.

Medical Insurance

The good news is that your Medical Insurance can be used if you have an eye-related medical problem, such as an eye injury, pink eye, double vision, headaches, cataract, dry eyes, glaucoma, or issues related to diabetes or high blood pressure (among many others). You **DO NOT** need a vision benefits rider on your medical insurance to be covered for a medical eye condition. In these cases, your Medical Insurance will be billed for the eye exam *even though a Vision Plan may also be in effect*. Your Medical insurance co-pays and deductibles prevail and must be paid at the time of your examination. Additionally, if we do file the exam with your medical insurance, you can still use your Vision Plan benefits toward the purchase of glasses or contact lenses, based on your plan and allowances.

At times it can seem like a complicated process, but these are the rules set by the insurance companies. We would be happy to answer any questions that you may have about your coverage.

Once your exam and materials have been filed with your insurance provider (at the conclusion of your visit) we CANNOT ALTER or CHANGE your examination, materials, diagnosis codes or bill another other insurance.

I have read the notice of Houser Newman Associates and agree to the terms set forth herein.

_____ _____

Patient Name *Date of Birth*

_____ _____

Signature of Patient and/or Guardian *Date*

Main Office
37 Medical Crossing Road
Tamaqua, PA 18252
P: (570) 386-5926
F: (570) 386-2959

Palmerton Office
217 Franklin Avenue, Suite 105
Palmerton, PA 18071
P: (570) 386-5926
F: (610) 826-3860

Nesquehoning Office
40 East Locust Street
Nesquehoning, PA 18240
P: (570) 386-5926
F: (570) 669-7083

PATIENTS: Please fill in the medication name, dose, and frequency of each of your medications. Please also list any over-the-counter medications, vitamins, and herbal supplements.

PATIENT NAME:_____ **BIRTHDATE:**_____

LIST YOUR CURRENT MEDICATIONS, DOSE, AND FREQUENCY HERE:

Medication Name	Dose	Frequency
Metoprolol	*50 mg*	*one daily*

PATIENTS: Please list only **TRUE ALLERGIES** which are medications that have caused you to have a rash, swelling, itching, hives, shortness of breath, respiratory or cardiac arrest. If you have had other reactions to a medication, please discuss these medications and reactions with the nurse.

PATIENT NAME:_____ **BIRTHDATE:**_____

LIST YOUR ALLERGIES AND REACTIONS HERE:

Medication Name	Medication Reaction
Example: Metoprolol	Hives, Shortness of breath

CONFIDENTIAL MEDICAL HISTORY FORM

NAME:_____ DATE OF BIRTH:_____

PAST/CURRENT PERSONAL MEDICAL HISTORY: Have YOU EVER had any of the following (CHECK BOX FOR YES):

HEART & LUNGS

- □ Asthma
- □ COPD
- □ Heart Disease
- □ Heart Murmur
- □ High Blood Pressure
- □ High Cholesterol
- □ Pneumonia

ENDOCRINE

- □ Adrenal Disorder
- □ Diabetes
- □ Polycystic Ovary
- □ Thyroid Disorder

KIDNEY

- □ Chronic Kidney Disease
- □ Kidney Stones

SKIN

- □ Eczema
- □ Psoriasis
- □ Hives

□ I HAVE NO SIGNIFICANT HEALTH PROBLEMS

STOMACH & BOWEL

- □ Celiac Disease
- □ Irritable Bowel Syndrome
- □ Stomach Ulcers
- □ Ulcerative Colitis/Crohn's
- □ Other

NEUROLOGICAL

- □ Concussion
- □ Migraine Headaches
- □ Multiple Sclerosis
- □ Muscular Dystrophy
- □ Seizures
- □ Stroke/TIA

MENTAL HEALTH

- □ ADHD
- □ Alcohol Abuse
- □ Anorexia
- □ Anxiety
- □ Bulimia
- □ Depression
- □ Drug Addiction

□ Other Mental Health Problem:

HEMATOLOGY & ONCOLOGY

- □ Anemia
- □ Bleeding Disorder
- □ Blood Clots
- □ Cancer
- □ Radiation/Chemo Therapy

ORTHOPEDICS

- □ Arthritis
- □ Fractures

STDs & INFECTIOUS DISEASE

- □ Chlamydia
- □ Herpes/Cold Sores
- □ Chickenpox/Shingles
- □ Hepatitis Type:____
- □ HIV
- □ Infectious Mono
- □ Tuberculosis

OPHTHALMOLOGY

□	Cataracts	□	Macular Degeneration
□	Cornea	□	Macular Edema
□	Diabetic Retinopathy	□	Oculoplastic issue
□	Dry Eye	□	Other Retinal issue
□	Glaucoma	□	Uses Glasses/contacts
□	Loss of Eye	□	Other eye issue:

PREVIOUS HOSPITALIZATIONS:

SOCIAL HISTORY

- □ Do you drink alcohol?
- □ Do you smoke?
- □ Do you take drugs?
- □ Do you exercise?

SURGICAL HISTORY

- □ Appendix removal
- □ Adenoid removal
- □ Cataract removal
- □ Ear tubes
- □ Gallbladder removal
- □ Hip replacement
- □ Knee replacement
- □ Organ Transplant
- □ Spleen removal
- □ Tonsil removal
- □ Weight loss surgery
- □ Other Surgery

OTHER HEALTH PROBLEMS/SURGERIES NOT LISTED:

DOES YOUR IMMEDIATE FAMILY HAVE ANY OF THE FOLLOWING? □ I WAS ADOPTED (UNKNOWN HISTORY)

	MOTHER	FATHER	SIBLINGS	GRANDPARENT
Alcohol/Drug Abuse				
Blood Clots/Clotting Disorder				
Cancer (Breast, colon, melanoma, other (list type under person)				
Diabetes				
Eye Disease/Disorders				
Heart Disease				
High Blood Pressure				
High Cholesterol				
Mental Illness				
Stroke/TIA				
Sudden Cardiac Arrest (Under age 50)				
Other (please explain under person)				
Deceased (Prior to age 50 please list reason)				