NANCY H. COLES, MD

PATIENT REGISTRATION AND HISTORY

DATE: _____

PATIENT NAME: _____ DATE OF BIRTH: _____
(Last) (First) (Middle)

ADDRESS: _____
(Street) (City) (State) (Zip)

TELEPHONE NUMBERS: HOME: ( ) _____ CELL: ( ) _____ WORK: ( ) _____

BEST TIME AND PLACE TO REACH YOU: _____

SS#: _____ E-MAIL ADDRESS: _____

OCCUPATION: _____

INTERNIST / PCP NAME : _____ PHONE: ( ) _____ FAX ( ) _____

CHECK ONE: SEX: M☐ F☐ CHECK ONE: MARRIED☐ PARTNERED☐ SINGLE☐ WIDOWED☐ DIVORCED☐

SPOUSE / PARTNER NAME: _____ BIRTHDATE: _____

SPOUSE'S EMPLOYER: _____

IN CASE OF EMERGENCY CONTACT:

NAME: _____ RELATIONSHIP: _____

HOME ( ) _____ CELL ( ) _____ WORK ( ) _____

WHOM MAY WE THANK FOR REFERRING YOU: _____

MEDICARE INSURANCE INFORMATION

MEDICARE INSURANCE: **POLICY #:** _____

Is patient covered by additional insurance? YES☐ NO☐

SECONDARY INSURANCE: **INSURANCE COMPANY:** _____ **POLICY #:** _____

Subscriber Name: _____ Relationship to Patient: _____

MEDICARE ASSIGNMENT AND RELEASE: I certify that I, and/or my dependent(s), have insurance coverage with **PART B MEDICARE** and assign directly to **Nancy H. Coles, MD** all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. **The above named doctor may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.**

I request the payment of authorized Medicare benefits, and, if applicable, Medigap benefits, be made to either me or on my behalf to, **Nancy H. Coles, MD.** To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid services, my Medigap insurer, and their agents, any information needed to determine these benefits for related services.

Signature of Patient, Beneficiary, Guardian or Personal Representative: _____

COMMERICAL INSURANCE INFORMATION

INSURANCE COMPANY: _____ **POLICY #:** _____

HEALTH HISTORY

Place a check on "YES" or "NO" to indicate if you have had any of the following:

Aids/HIV	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Artif. Heart Valve	☐ Yes ☐ No	Hay fever	☐ Yes ☐ No	Shingles	☐ Yes ☐ No
Artificial joints	☐ Yes ☐ No	Lupus	☐ Yes ☐ No	Skin Condition	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Bleeding	☐ Yes ☐ No	Hepatitis (type__)	☐ Yes ☐ No	Thyroid Conditions	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	High BP	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Diabetes (type__)	☐ Yes ☐ No	Migraines	☐ Yes ☐ No	Tumors	☐ Yes ☐ No

Are you pregnant:_____ Number of children:_____

Tobacco use:_____ Alcohol use:_____

PAST OCULAR HISTORY

Dry Eye Syndrome ☐ Yes ☐ No

Cataract Surgery Right Eye ☐ Yes ☐ No (Date:_____)

Cataract Surgery Left Eye ☐ Yes ☐ No (Date:_____)

Diabetic Retinopathy ☐ Yes ☐ No

Eye Lid Surgery ☐ Yes ☐ No

Floaters ☐ Yes ☐ No

Glaucoma ☐ Yes ☐ No (Last Testing:_____)

LASIK Surgery ☐ Yes ☐ No (Date:_____)

Lazy eye as a child ☐ Yes ☐ No

Macular Degeneration ☐ Yes ☐ No

Muscle Surgery ☐ Yes ☐ No

Retinal Surgery ☐ Yes ☐ No

Other: _____

FAMILY OCULAR HISTORY

Age- Related Macular Degeneration

☐ Yes ☐ No Who?_____

Cataracts ☐ Yes ☐ No Who?_____

Glaucoma ☐ Yes ☐ No Who?_____

Retinal Detachment

☐ Yes ☐ No Who?_____

Other: _____

_____

ALLERGIES: List any allergies to medications and/or substances:

_____

_____

UPDATED MEDICATION LIST

Patient Name:_____

Date Updated:_____

Pharmacy Name:_____

Pharmacy Address:_____

Pharmacy Telephone number:_____

ALLERGIES:_____

CURRENT MEDICATIONS: PLEASE INCLUDE EYE DROPS

Name of Medication	Strength	How Often	What is Medication For?

SPEED™ QUESTIONNAIRE

Name: _____ Date: ___/___/___ Sex: M F (Check One) DOB: ___/___/___

For the Standardized Patient Evaluation of Eye Dryness (SPEED) Questionnaire, please answer the following questions by checking the box that best represents your answer. Select only one answer per question.

1. Report the type of SYMPTOMS you experience and when they occur:

	At this visit		Within past 72 hours		Within past 3 months	
Symptoms	Yes	No	Yes	No	Yes	No
Dryness, Grittiness or Scratchiness	☐	☐	☐	☐	☐	☐
Soreness or Irritation	☐	☐	☐	☐	☐	☐
Burning or Watering	☐	☐	☐	☐	☐	☐
Eye Fatigue	☐	☐	☐	☐	☐	☐

2. Report the FREQUENCY of your symptoms using the rating list below:

Symptoms	0	1	2	3
Dryness, Grittiness or Scratchiness	☐	☐	☐	☐
Soreness or Irritation	☐	☐	☐	☐
Burning or Watering	☐	☐	☐	☐
Eye Fatigue	☐	☐	☐	☐

0 = Never **1** = Sometimes **2** = Often **3** = Constant

3. Report the SEVERITY of your symptoms using the rating list below:

Symptoms	0	1	2	3	4
Dryness, Grittiness or Scratchiness	☐	☐	☐	☐	☐
Soreness or Irritation	☐	☐	☐	☐	☐
Burning or Watering	☐	☐	☐	☐	☐
Eye Fatigue	☐	☐	☐	☐	☐

0 = No Problems
1 = Tolerable - not perfect, but not uncomfortable
2 = Uncomfortable - irritating, but does not interfere with my day
3 = Bothersome - irritating and interferes with my day
4 = Intolerable - unable to perform my daily tasks

4. Do you use eye drops for lubrication? ☐ YES ☐ NO If yes, how often? _____

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For office use only
Total SPEED score (Frequency + Severity) = ___/28

Nancy H. Coles, MD
125 East 72nd Street
New York, NY 10021
(212) 879-8886

HIPPA COMPLIANCE PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, I understand that:

- Protected health intonation may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? **YES** ☐ **NO** ☐

May we leave a message on your answering machine at home or on your cell phone? **YES** ☐ **NO** ☐

May we discuss your medical condition with any member of your family or a friend? **YES** ☐ **NO** ☐

If YES, please **name the members allowed:**

_____

This consent was signed by: _____ **(PRINT NAME)**

SIGNATURE: _____ **DATE:**_____

NANCY H. COLES, MD

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New York, NY 10021
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PATIENT FINANCIAL AGREEMENT
MEDICARE PARTICIPATING INSURANCE

We are dedicated to providing the best possible service to you and regard your complete understanding of your financial responsibilities as an essential element of your treatment and care.

One of the most important parts of your eye exam today is the vision evaluation. That is the part of the exam by which we determine whether you can be helped in any way by a new glasses' prescription. It is also how we determine the best possible visual acuity and function of your eye, which is essential medical information for us to have as we assess your eyes and look for problems. It is NOT a covered service by Medicare and many other insurance plans. These plans consider this a "vision" service not a "medical" service. Our office fee for vision evaluation is $ 50.00 and this fee is collected at the time of service.

I accept full financial responsibility for the cost of this service and understand it is due at time of service. I understand that any co-payment, coinsurance and/or deductibles are separate from and not included in the vision evaluation fee.

CREDIT CARD INFORMATION

I authorize **NANCY H COLES MD**, to charge balances on my account to the credit card listed below.

CARD HOLDER NAME: _____

ZIP CODE: _____

CREDIT CARD TYPE: _____

CREDIT CARD NUMBER: _____

EXPIRATION DATE: _____ **CVC:** _____

My signature below is recognized by the credit card issuer for valid transactions:

Patient Signature: _____ Date: _____

Print Name: _____