Cassandra B. Onofrey, MD, PA

Patient Information

Today's Date _____ Date of Birth _____

Name _____ M / F Social Security # _____

Address _____ Apt # _____ Bldg # _____

City _____ State _____ Zip Code _____

Hm Phone # _____ Cell # _____ Email _____

OUT OF STATE ADDRESS

Address _____ Apt # _____ Bldg # _____

City _____ State _____ Zip Code _____ Phone # _____

EMPLOYER INFORMATION

Your Employer _____ Title _____ Work Ph _____

Spouse's Name _____ Employer _____

Title _____ Work Ph _____

CONTACT IN CASE OF EMERGENCY

Name _____ Relationship _____ Phone # _____

Complete if under 18 years of age or a student

Name of Father _____ Employer _____

Address _____ Phone # _____

Name of Mother _____ Employer _____

Address _____ Phone # _____

INSURANCE INFORMATION

(Please have insurance card and photo ID available)

Primary Insurance Coverage _____ Name of Insured _____
Relationship to Insured: ☐ Self ☐ Spouse ☐ Dependent
ID# _____ Group # _____

Secondary Insurance Coverage _____ Name of Insured _____
Relationship to Insured: ☐ Self ☐ Spouse ☐ Dependent
ID# _____ Group # _____

Cassandra B. Onofrey, MD, PA

Primary Medical Doctor: _____ Doctor's Phone # _____

Primary Eye Doctor: _____ Doctor's Phone # _____

Date last eye exam: _____ Referred by: _____

Pharmacy Phone # _____

REASON FOR INITIAL VISIT: _____

Are you ALLERGIC to any medications? ☐ Yes ☐ No (if yes, please list below)

_____

List any MEDICATIONS you currently take (prescription and over-the-counter):

_____

_____

_____

List any EYE DROPS you use: _____

List all MAJOR ILLNESSES (glaucoma, diabetes, high blood pressure, heart attack, etc) or injuries:

_____

_____

_____

List any GENERAL SURGERIES you have had (sinus, heart, vascular stents, joint replacement):

_____

_____

Please list any EYE SURGERY or SURGERY TO YOUR EYELIDS/FACE:

Year	Type of Surgery	Which eye	Surgeon

Please check the appropriate boxes for symptoms you currently have:

☐ Dryness of the eye	☐ Light sensitivity	☐ Excess tearing/watering
☐ Mucous discharge	☐ Eye pain/soreness	☐ Loss of superior vision
☐ Redness of eyes	☐ Eyelid growths or cancers	☐ Lid infections
☐ Sandy or gritty feeling	☐ Tired eyes	☐ Styes
☐ Itching / burning of eyes	☐ Eyes closing with reading	☐ Drooping eyelids
☐ Double vision	☐ Headaches	☐ Excess eyelid skin

WOULD YOU LIKE INFORMATION REGARDING.....

Cosmetic Eyelid Surgery	yes	no
Botox® injections	yes	no

_____

Patient Name

Cassandra B. Onofrey, MD, PA

Do you currently have problems with .....

	YES	NO	Explanation of Problem
General Constitution (Fever, weight loss, etc)			
Ears, Nose, Throat (Sinus, chronic cough)			
Cardiovascular (Heart, blood vessels, etc)			
Respiratory (Asthma, emphysema, COPD)			
Gastrointestinal (Stomach ulcers, IBS, etc)			
Kidney, Bladder			
Muscles, Bones, Joints (arthritis, etc)			
Skin (Acne, warts, skin cancer, etc)			
Neurological (multiple sclerosis, stroke)			
Psychiatric (Anxiety, depression, insomnia)			
Endocrine (diabetes, thyroid, etc)			
Blood/Lymph (High Cholesterol, anemia, etc)			
Allergy/Immunologic: Hay fever, lupus, Sjogrens, HIV			

FAMILY HISTORY M = mother F = father S = sibling GP = grandparent

	Yes	No	Relationship to Patient
Blindness			
Cancer			
Diabetes			
Heart disease/high blood pressure			
Kidney disease			
Lupus			
Stroke			
Thyroid disease			

SOCIAL HISTORY

Current/past occupation: _____ Education (highest level): _____

Marital status: ☐ married ☐ divorced ☐ single ☐ widowed Do you live alone? ☐ Yes ☐ No
Do you drive? ☐ Yes ☐ No Do you have visual difficulty with driving? ☐ Yes ☐ No
Do you currently wear contact lenses? ☐ Yes ☐ No or glasses? ☐ Yes ☐ No
Do you drink alcohol? ☐ Yes ☐ No If YES: occasional 1 per day 2-3/day 4+/day
Do you smoke? ☐ Yes ☐ No If YES: occasional ½ pack /day 1 pack/day 1+pack/day
Have you ever had a blood transfusion? ☐ Yes ☐ No

Patient signature: _____ Date: _____ MD initials: _____

_____
Patient Name

Cassandra B. Onofrey, MD, PA

Consent for Treatment

I voluntarily present to Cassandra B. Onofrey, MD, PA for medical evaluation, diagnosis, and/or treatment. I consent and authorize my provider(s) or her designee(s) to provide diagnostic and medical treatment which may be necessary or advisable in their professional judgment. By signing this consent form, I do not waive my right to refuse recommended tests or treatment.

_____ _____

Patient Initials Date

Consent to Release Medical Information

In April of 2003, new federal requirements regarding privacy of information for health care patients took effect. HIPAA, the Health Insurance Portability and Accountability Act, requires that all medical providers, insurance companies and others, put in place controls to ensure that your personal medical information is safe.

Cassandra B. Onofrey, MD, PA requests that each patient sign this consent form which allows us to share protected health information with other physician offices, your hospital and insurance company. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent.

_____ _____

Patient Initials Date

Financial Assignment and Agreement

1. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. We verify benefits and bill your supplement as a courtesy. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance. ***Should account not be paid, you assume all costs of collection, including, but not limited to collection fees of 30%, court costs, interest and legal fees.***
2. Patient responsibilities are due at the time services are rendered.
3. I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration, its agents, or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services.
4. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

_____ _____

Patient Initials Date

_____

Patient Name

Cassandra B. Onofrey, MD, PA

INFORMATION DISCLOSURE FORM

Please list below the people with whom we can discuss your health care:

Name_____

Relationship_____

Contact Number_____

Name_____

Relationship_____

Contact Number_____

Name_____

Relationship_____

Contact Number_____

□ **Please <u>DO NOT</u> discuss my healthcare with anyone but myself.**

_____ _____

Patient name (print) Patient signature