SCOTT W. TUNIS MD FACS
EYE PHYSICIAN AND SURGEON

PATIENT INFORMATION

Patient and Responsible Party Information

FIRST NAME_____MI___LAST NAME_____(JR,SR,ETC)___ NICKNAME_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

HOME PH# (_____)_____ WORK PH#(_____)_____ CELL PH#(_____)_____

BIRTHDATE_____/_____/_____ SEX ____ RACE _____ MARITAL STATUS_____

SOC SEC #_____-_____-_____ EMAIL ADDRESS_____

EYE PROBLEM AS A RESULT OF EMPLOYMENT? YES / NO DATE OF INJURY / ILLNESS _____/_____/_____

EMPLOYER_____ EMPLOYER TELEPHONE (_____)_____

EMPLOYER ADDRESS_____ CITY_____ STATE_____ ZIP_____

CURRENT EYE DOCTOR _____ REFERRED BY _____

Insurance Information (Please present card(s) to receptionist)

PRIMARY INSURANCE CO._____ SECONDARY INSURANCE CO._____

POLICY HOLDER_____ POLICY HOLDER_____

POLICY HOLDER SS#_____-_____-_____ POLICY HOLDER SS#_____-_____-_____

POLICY HOLDER DATE OF BIRTH____/_____/_____ POLICY HOLDER DATE OF BIRTH_____/_____/_____

RELATION TO PATIENT: *SELF SP CH OTHER* RELATION TO PATIENT: *SELF SP CH OTHER*

Acknowledgment

_____ IF INSURANCE IS FILED ON MY BEHALF, I AUTHORIZE MY INSURANCE BENEFITS TO BE PAID
initial DIRECTLY TO SCOTT W. TUNIS MD FACS

_____ I AGREE THAT UNLESS SCOTT W. TUNIS MD FACS AND MY INSURER HAVE A PRIOR
initial AGREEMENT, I AM PERSONALLY RESPONSIBLE FOR ALL NON-COVERED SERVICES, CO-PAYS AND DEDUCTIBLES.

_____ I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION TO INSURANCE CARRIERS OR OTHER
initial PHYSICIANS IF IT IS DEEMED NECESSARY BY MY OPHTHALMOLOGIST FOR FINANCIAL OR CONSULTATIVE PURPOSES.

_____ I ACKNOWLEDGE RECEIPT OF SCOTT W. TUNIS MD FACS NOTICE OF PRIVACY PRACTICES.
initial

RESPONSIBLE PARTY (SIGNATURE)_____ DATE_____/_____/_____

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PATIENT HISTORY

CHART#:

PATIENT NAME:	DOB: ____/____/_____	TODAY'S DATE: ____/____/_____

REASON FOR VISIT/COMPLAINT:_____

WHEN DID IT START?_____ HOW OFTEN DOES IT BOTHER YOU?_____

HAVE YOU BEEN TREATED FOR THIS PREVIOUSLY? YES / NO BY WHOM?_____

REFERRING EYE DOCTOR:_____ PRIMARY CARE DOCTOR:_____

REVIEW OF SYSTEMS: DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING? (Check all that apply)

- ☐ Hearing Loss
- ☐ Asthma
- ☐ Arrhythmia (abnormal heart rhythm)
- ☐ Chest pressure or discomfort
- ☐ Irregular heartbeat/Palpitation
- ☐ Tachycardia (rapid heart rate)
- ☐ Abdominal pain
- ☐ Nausea
- ☐ Urgency (constant urge to urinate)
- ☐ Thyroid imbalance
- ☐ Diabetes
- ☐ Loss of balance
- ☐ Headache
- ☐ Bruising
- ☐ Anxiety
- ☐ Depression
- ☐ Dementia/Alzheimer's/Memory difficulty
- ☐ Skin changes
- ☐ Osteoarthritis
- ☐ Rheumatoid arthritis
- ☐ Seasonal Allergies
- ☐ Autoimmune disease_____
- ☐ Infectious disease _____
- ☐ Other_____

MEDICAL HISTORY: (Please use back side of form if you need more room)

DO YOU USE *OR* HAVE YOU EVER USED FLOMAX (TAMSULOSIN) FOR URINARY ISSUES? YES / NO

DRUG ALLERGIES:_____

ARE YOU ALLERGIC TO LATEX (RUBBER GLOVES, CONDOMS, ADHESIVE TAPE, BAND-AIDS, ETC.)? YES / NO

CURRENT MEDICATIONS & EYE DROPS:_____

_____

_____

PREVIOUS EYE ISSUES:_____

PREVIOUS SURGERIES/DISEASES/HEALTH ISSUES:_____

_____

ANY HISTORY OF CARDIAC/HEART DISEASE/STENTS? YES / NO _____

ANY HISTORY OF MRSA (ANTIBIOTIC RESISTANT STAPH INFECTION)? YES / NO WHEN?_____

FAMILY HISTORY: (Abbreviate F=Father, M=Mother, S=Sibling, G=Grandparent) ☐ None ☐ Unknown

☐ Diabetes _____ ☐ Hypertension _____ ☐ Heart Disease _____ ☐ Thyroid Disease_____

☐ Cancer_____ ☐ Eye Disease (specify type)_____ ☐ Other_____

SOCIAL HISTORY: (Required by insurance)

Tobacco Use: ☐ Current ☐ Never ☐ Former Type?_____ Amount per day?_____ Years used?_____

Tried to quit? Y / N Relapse reason?_____ If former, year quit: _____ Longest tobacco free: _____

Alcohol Use? YES / NO / FORMERLY Drug Use/Abuse? YES / NO / FORMERLY

Caffeine Use? YES / NO IF YES, HOW MANY CUPS PER DAY?_____

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NOTICE OF PRIVACY PRACTICES

WE ARE REQUIRED BY LAW TO PROVIDE YOU WITH THIS NOTICE AND TO MAINTAIN THE PRIVACY OF YOUR HEALTH INFORMATION. A COPY OF OUR PRIVACY POLICY IS AVAILABLE IN THE OFFICE FOR ALL PATIENTS TO READ AND A PAPER COPY OF THIS POLICY IS AVAILABLE UPON REQUEST TO ANY PATIENT.

IN ORDER FOR US TO DISCUSS ANY OF YOUR PRIVATE INFORMATION WITH A FAMILY MEMBER OR FRIEND (INCLUDING YOUR SPOUSE), THEIR NAME(S) MUST BE LISTED ON THIS FORM IN THE SECTION BELOW.

1) I AUTHORIZE SCOTT W. TUNIS MD FACS TO RELEASE MY HEALTH INFORMATION TO:

_____	_____	_____
PERSON OR ENTITY	RELATIONSHIP	PHONE NUMBER
_____	_____	_____
PERSON OR ENTITY	RELATIONSHIP	PHONE NUMBER

2) THIS AUTHORIZATION FOR RELEASE OF INFORMATION COVERS THE PERIOD OF HEALTHCARE:

☐ FROM _____ TO _____ *OR* ☐ ALL PAST, PRESENT, AND FUTURE PERIODS.

3) I AUTHORIZE THE RELEASE OF:

☐ MY COMPLETE HEALTH RECORD

☐ MY COMPLETE HEALTH RECORD WITH THE EXCEPTION OF THE FOLLOWING INFORMATION:

_____

THIS MEDICAL INFORMATION MAY BE USED BY THE PERSON I AUTHORIZE TO RECEIVE THIS INFORMATION FOR MEDICAL TREATMENT OR CONSULTATION, BILLING OR CLAIMS PAYMENT, OR OTHER PURPOSES AS I MAY DIRECT.

THIS AUTHORIZATION SHALL BE IN FORCE AND EFFECT UNTIL _____ (DATE OR EVENT), AT WHICH TIME THIS AUTHORIZATION EXPIRES.

I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION, IN WRITING, AT ANY TIME. I UNDERSTAND THAT A REVOCATION IS NOT EFFECTIVE TO THE EXTENT THAT ANY PERSON OR ENTITY HAS ALREADY ACTED IN RELIANCE ON MY AUTHORIZATION OR IF MY AUTHORIZATION WAS OBTAINED AS A CONDITION OF OBTAINING INSURANCE COVERAGE AND THE INSURER HAS A LEGAL RIGHT TO CONTEST A CLAIM.

I UNDERSTAND THAT MY TREATMENT, PAYMENT, ENROLLMENT, OR ELIGIBILITY FOR BENEFITS WILL NOT BE CONDITIONED ON WHETHER I SIGN THIS AUTHORIZATION.

I UNDERSTAND THAT INFORMATION USED OR DISCLOSED PURSUANT TO THIS AUTHORIZATION MAY BE DISCLOSED BY THE RECIPIENT AND MAY NO LONGER BE PROTECTED BY FEDERAL OR STATE LAW.

_____ DATE ____ / ____ / _____
PATIENT SIGNATURE

_____
PATIENT NAME (PLEASE PRINT)

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Financial Policy: All Patients Please Read and Sign

Payment is due at the time of service unless arrangements have been made in advance. If you are not prepared to pay for services rendered today, please notify the receptionist before you are seen by the doctor. We accept cash, checks, Visa, MasterCard, Discover, American Express, CareCredit, Wells Fargo Health Advantage and Alphaeon Credit. Please see additional information below and sign at the bottom of the page.

MEDICARE: We are a participating Medicare provider. Your fees will be based on what Medicare ALLOWS for our services. You will pay only your deductible if it is not met for the year, as well as your 20% copayment on any charges beyond the deductible amount. You will also be asked to pay for any non-covered services. We will notify you ahead of time if the service to be performed is not covered by Medicare. If you have a secondary insurance and wish us to file it for you, please notify us so that we may verify the coverage.

HMO/PPO INSURANCE COMPANIES: If your insurance company is an HMO or PPO (Preferred Provider Organization) with whom we are associated, you will be required to pay based upon your policy guidelines. **Copayments and deductibles are due at the time of service.** If you policy requires a referral from your primary care physician, it is your responsibility to obtain this and provide us with a copy. If your insurance company denies payment due to not obtaining a referral, you will be responsible for paying our full fees. ***WE MUST BE ABLE TO VERIFY YOUR INSURANCE COVERAGE PRIOR TO YOUR VISIT. IF WE ARE UNABLE TO DO SO, YOU WILL BE ASKED TO PAY OUR FULL FEES AT THE TIME OF SERVICE. IF COVERAGE IS LATER VERIFIED, WE WILL BE HAPPY TO REFUND ANY OVERPAYMENT ONCE YOUR CLAIM HAS BEEN PROCESSED.***

SURGERY: We will file surgery charges with your insurance company, but the final responsibility for payment of all charges is ultimately yours – not your insurance company. If for any reason your insurance company does not pay as anticipated, you will be required to pay the balance.

Prior to any scheduled surgery, we will require payment for your procedure, depending upon your insurance coverage. This payment will include pre-payment for any deductible, copayment, and coinsurance amounts, as well as any non-covered services or supplies to be dispensed from our office.

Please sign that you have read, understand, and accept our financial policy. This signature also authorizes payment of insurance benefits to the physician and the release of medical records to process your claim (see below).

Patient Signature _____ Date _____

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO DR. SCOTT W. TUNIS AND MEDICAL BENEFITS OTHERWISE PAYABLE TO ME FOR HIS SERVICES. I UNDERSTAND THAT THIS DOES NOT RELEASE ME FROM MY PERSONAL RESPONSIBILITY FOR PAYMENT OF CHARGES NOT PAID BY MY INSURANCE COMPANY. I ALSO AUTHORIZE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIM(S). THIS AUTHORIZATION SHALL BE VALID UNTIL REVOKED AND A PHOTOCOPY SHALL BE AS THE ORIGINAL.