New Century Ophthalmology, PC
Medical, Laser, and Surgical Eye Care
1610 Williamsboro Street, Oxford, NC 27565
Phone: (919) 693-6661 Fax: (919) 690-1160

Vinod K. Jindal, MD, FACS
Board Certified Ophthalmologist and
Retina Specialist

Patient Name: _____
First **Middle** **Last**

Date of Birth: _____ **Social Security #:** _____ **Race:** _____

Please circle one of the following: Gender: Female / Male Marital Status: Single, Married, Divorced, Widow

Mailing Address: _____
Street Name **City** **State** **Zip Code**

Physical Address (if different from mailing): _____

Home Phone: _____ **Cell:**_____ **Email:** _____

Emergency Contact: _____ **Phone #:** _____**Relationship:** _____

Primary Care Provider: _____ **Phone #:**_____

Referring Provider:_____ **Phone #:**_____

Preferred Pharmacy:_____ **Location:**_____
Secondary Pharmacy: _____ **Location:**_____

Primary Medical Insurance: _____ **Id #:**_____ **Group #:**_____
Secondary/Supplemental Ins:_____ **Id #:**_____ **Group #:**_____
Responsible Party: _____ **Date of Birth:** _____ **SSN#:** _____
Relationship: Self / Mother / Father / Spouse Accident Related: Yes / No Employer: _____

Financial Responsibilities & Assignment of Insurance Benefits:

I understand that my insurance policy is contracted with I, not with New Century Ophthalmology, PC (NCO, PC). I understand that I am personally responsible to the physician for all charges for services that are not covered by my insurance. I understand that in the event that New Century Ophthalmology, PC (NCO, PC) is not in-network with my insurance carrier, I will be responsible for 100% of the charges incurred. I understand that all Copays and deductibles are due at the time of service. I understand that New Century Ophthalmology, PC reserves the right to review all agreements on an individual basis to determine the continued acceptance of assignment for Medicare and/or any other medical insurance companies. In the event medical necessity no longer exists or my payer no longer deems my consult to be covered, I understand I will be responsible for any balance due. I acknowledge receipt and understanding of my Patient/Client Bill of Rights, and Notice of Privacy Practices. I agree that NCO, PC may contact me in the future, via telephone, email, instant messaging, mail or other means of communication, regarding my upcoming appointments and/or balances due.

Patient Signature:_____ **Date:** _____

I request that payment of authorized Medicare and/or private insurance benefits be made either to me or on my behalf to New Century Ophthalmology, PC (NCO,PC) for any services furnished to me by NCO, PC. I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services and/or my private insurance, and its agents, any information needed to determine these benefits or the payable benefits for the related services.

Patient Signature:_____ **Date:**_____

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HISTORY AND REVIEW OF SYSTEMS

Patient Name:_____ **Date of Birth:**_____
Last Eye Exam Date:_____ **Where was it done?**_____
Do you use glasses? Yes / No **Do you use contact lenses? Yes / No** **What brand?**_____

Please answer the following questions about your medical history. Please circle all that apply.

Have you ever been treated for any of the following conditions: Diabetes (Type 1 or 2) - Hypertension Heart disease - Heart Attack - Lung Disease - Thyroid - Arthritis - Cancer - High Cholesterol
Have you ever been treated for any of the following ocular problems: Blepharitis - Cataract - Dry Eye Glaucoma - Macular Degeneration - Retinal Tears - Retinal Detachment - Strabismus - Other_____
Have you had any of the following medical or ocular surgeries: Heart Sx - Cancer - Cataract - Laser Treatments - Retinal - Ptosis - Refractive (Lasek) - Ocular Injections - Other:_____
Family history of medical or ocular diseases?If so, please state who?
Diabetes - Hypertension - High Cholesterol - Heart Disease - Heart Attack - Stroke - Arthritis - Cancer - Blindness - Cataract - Glaucoma - Macular Degeneration - Retinal Detachments - Other:_____
_____
Do you currently have any of the following symptoms?
Rashes - Excessive Dryness - Hearing Loss - Sinus Problems - Sore Throat - Chest Pain - Irregular Heartbeat - Shortness of Breath - Wheezing - Coughing - Fatigue - Heartburn - Abdominal Pain - Diarrhea - Vomiting - Muscle Aches - Joint Pain - Swollen Joints - Paralysis - Numbness/Weakness - Weight Gain/Loss - Anxiety - Depression - Other:_____
Do you currently have any of the following problems?(Chief Complaint)
Loss of Vision: Right / Left Eye - Deceased Vision - Foreign Body Sensation - Headaches - Flashes of Light - Blurry Vision - Floaters (ex.Black Spots/Lines) - Pain - Burning - Irritation - Redness - Itchiness - Photophobia(Light Sensitivity) - Other:_____
Are you allergic to any medications such as:
Amoxycillin - Antihistamines - Aspirin - Codeine - Contrast Dye - Erythromycin - Hydrocodone - Ibuprofen - Iodine - **Latex** - Morphine - Neosporin - Prednisone - Penicillin - Steriods - Sulfa Drugs -
Other:_____

Do you smoke? Former / Current (How many packs?___) / Never
Do you drink alcoholic beverages? Occasionally / Socially / Every Day (How much?_____)
Do you use any drugs? Yes / No
Do you take any Medications: Yes / No **Please list all current medications.**

_____
_____
_____

Do you use any eye drops or ointments? Prescribed or Over-the-counter

_____

Reviewed by:_____ **Date:**_____
Provider Signature

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for **New Century Ophthalmology, PC (NCO,PC)**, to use and disclose **protected health information (PHI)** about me to carry out **treatment, payment and healthcare operations (TPO)**. (**NCO,PC's** Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I understand that I have the right to review the **Notice of Privacy Practices** prior to signing this consent **NCO,PC** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **New Century Ophthalmology, PC** Privacy Officer at **P.O. Box 914, 1610 Williamsboro Street, Oxford NC 27565**.

I understand that with this consent, **NCO,PC** may contact me in the future, via telephone, email, instant messaging, mail or other means of communication and to leave a voice message if necessary. I understand that any emergency contact listed by me, **NCO,PC** has the consent to contact said person if necessary.

I understand that if any consultation or procedure/test is performed and not covered by my medical insurance provider, **NCO,PC** will place charges to my responsibility. I understand that I will be responsible for any balance not covered by my insurance. I understand that it is not **NCO,PC** responsibility to know if my insurance is an in-network insurance provider. I understand that if I do not present all medical insurance needed to bill for any service provided in a timely manner, I will be held responsible for charges denied for the timely filing limit.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this agreement, I understand that **New Century Ophthalmology, PC** will use and disclose any of my **PHI** to carry out treatment, payment and healthcare operations.

I understand that I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **New Century Ophthalmology, PC**, may decline to provide treatment to me.

A copy of **New Century Ophthalmology, PC's** privacy notice is posted and at my disposal should I want to review it. I understand that I may also request a copy of this form to keep for my records at any time.

_____
Signature of Patient or Legal Guardian

_____ _____
Print Patient's Name Date