Jeremy B. Meltzer, M.D

591 Lincoln street, Worcester MA 01605- Telephone 508-757-4160

New patient Information Form

Welcome to our office. Please complete both sides of this form and return it to the receptionist

1. Name: _____

2. Address: _____

3. Date of Birth: _____ Age: _____ Male/Female: _____

4. Telephone (Home) _____ Telephone Work: _____

5. Occupation: _____ Employer _____

Address/Phone _____

6. Name of Spouse: _____ Employer _____

Address/Phone _____

7. Complete if under 18 years or a student _____

Name of Father _____ Employer _____

Address/Phone _____

Name of Mother _____ Employer _____

Address/Phone _____

8. Name of referring Physician or patient _____

9. Are you personally responsible for the payment of your fees? Yes ☐ No ☐ If not, who is?

Name _____ Relationship _____

Address _____ Telephone # _____

10. Is there any part of your eye examination covered by insurance? Yes ☐ No ☐

If yes, please give your insurance card to us with this form.

11. How do you plan to pay for todays visit or co-pay? Cash ☐ Check ☐

Mastercard ☐ MC# _____ Expirationdate _____

Visa ☐ Visa# _____ Expiration date _____

_____ _____

Patient's Signature Date

12. Whom to notify in emergency (nearest relative or friend)

Name: _____ Relationship _____

Address _____

Home Phone _____ Work Phone _____

13. Do you have any of these eye problems? If so, check them:

Glaucoma ☐ Crossed Eyes ☐ Retinal Problems ☐ Eye injuries ☐ Cataracts ☐ Infections ☐

Double vision ☐ Blurred or Fuzzy vision ☐ Spots ☐ Halos ☐ Others_____

14. Have you ever had any eye operations or injuries? If so, what operations/injuries and when:

_____

15. Have you ever had any GENERAL HEALTH PROBLEMS? If so check them:

Sinus Infection ☐ Do you smoke? ☐ Allergies ☐ Diabetes ☐ Tuberculosis ☐ Surgery ☐

Skin disorders High Blood Pressure ☐ Headaches ☐ Bleeding tendency ☐ Hay fever ☐

Now pregnant ☐ Cancer ☐ Heart Trouble Thyroid trouble ☐ Asthma ☐ Now on oral contraceptives ☐

Others: ☐

_____

16. FAMILY HISTORY: Any of the following conditions in your family? Check them:

Glaucoma ☐ Strabismus (crossed eye) ☐ Retinal Problems ☐ Cataracts ☐ Blindness ☐ Diabetes ☐

Other_____

17. Are you taking any medications? If so, name them:

_____

_____

18. Are you ALLERGIC to any medications? If so, name them:

_____

_____

19. Who is your medical doctor? _____

20. Do you currently wear contact lenses? Yes ☐ No ☐

21. do you wish to pursue contact lenses in this office? Yes ☐ No ☐

Jeremy Meltzer, M.D.
Financial Agreement

Medicare – I request that payment of authorized benefits be made on my behalf to Jeremy Meltzer, M.D., for services furnished to me by Jeremy Meltzer, M.D. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) and its agents, any information needed to determine these benefits or the benefits payable for related services.

Medigap – I understand that if a Medigap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer of the agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Jeremy Meltzer, M.D. if possible, or otherwise to me.

1. I authorize the physician to release any medical information necessary to process all insurance claims.
2. If your insurance company requires a referral to see a specialist and we have not received one, you will be responsible for all charges incurred.
3. Keep in mind that your insurance policy is a contract between you and your insurance company. As a service to you, we will file your insurance claim if you assign the benefits to the doctor – in other words, if you agree to have your insurance pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. If we later receive a check from your insurer, we will refund any overpayments to you.
4. We have made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits. We will bill them, and if your insurance company requires a co-payment, it is due at the time of your visit.
5. Not all insurance plans cover all services. In the event your insurance plan determines a service as "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

I have read and understand the practice's financial policy and I agree to be bound by these terms. I also agree that such terms may be amended by the practice from time to time.

_____ _____

Signature of patient (or responsible party) Date

Health Insurance Portability and Accountability Act (HIPAA)

I, _____, acknowledge that I may have a copy of the HIPAA Notice of Privacy Practices for Jeremy Meltzer, M.D. and Medical Surgical Eye Institute, upon request.

Date:_____ Signed:_____