Advanced Ophthalmology Associates PLC
Barbara M. Kuczynski, M.D.
330 East Fourteen Mile Road, Suite B, Clawson, MI 48017 Phone: (248) 589-9500 Fax: (248) 589-9587

Statement of Treatment and Financial Agreement

Consent: I authorize and request medical treatment including, but not limited to, administration of anesthetics and analgesics (Note: eye drops, and eye medication are considered anesthetics and analgesics) and any treatments or test, which in the judgement of the physician and her associates or assistants, is deemed necessary. The responsibility for any follow-up examination to check abnormalities found lies with me and not with my physicians.

I hereby release my examiner from all responsibility in connection with this examination.

Financial Agreement: I understand that I am financially responsible for testing services or procedures that may not be covered under my health care plan. I understand that denied insurance claims become my responsibility. I agree to pay for all charges not covered by my insurance company, including deductibles and co-pays at the time of service. I understand that if I am a member of a managed care plan (HMO) and require a referral for my visit, it is my responsibility to obtain one prior to my visit. I understand that should I not have a referral I am financially responsible for the visit.
As a service to you, Advanced Ophthalmology Associates PLC participates with Medicare, Blue Cross Blue Shield, and many other insurance plans. We will submit claims to your insurance company for the medical services provided to you. Co-pays, deductibles, and non-covered services must be paid at the time of service.

Medicare and many health insurance plans DO NOT COVER the portion of your complete ophthalmic exam called the refraction- which determines your eyeglass prescription. The charge is $40.00. Please let us know in advance if you do not wish to have a refraction.

I understand and accept the above statements and consent to treatment.

_____ _____

Patient Signature (or person authorized to sign for patient) **Date**

Acknowledgement of Notice of Privacy Policy: I acknowledge that I have been made aware of and received/reviewed the notice of the Privacy Practices of this office.

_____ _____

Patient Signature (or person authorized to sign for patient) **Date**

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Patient Information

Legal Name: _____ Nick name: _____

Date of Birth: _____ Age: _____ Gender: _____ SS # _____

Address: _____

City: _____ State: _____ Zip code: _____

Cell Phone: _____ OK to text YES / NO Ok to leave message YES / NO

Home Phone: _____ Ok to leave message YES / NO

E-Mail address: _____ Marital Status S M W D

Emergency Contact: Name _____Phone Number_____

Employer (self) _____ Employer (spouse) _____

Primary Care Physician: Dr. _____ Referring Physician: Dr._____

How did you hear about us? _____

NAME OF PRIMARY INSURANCE: _____

Contract/ID/ACCT# _____ Group Number: _____

If Other Than Self:

Policy Holder's Name: _____ Relationship: _____

Date of Birth: _____ Social Security #: _____

NAME OF SECONDARY INSURANCE: _____

Contract/ID/ACCT # _____ Group Number: _____

If Other Than Self:

Policy Holder's Name: _____ Relationship: _____

Date of Birth: _____ Social Security #: _____

VISION INSURANCE OR OTHER MEDICAL INSURANCE: _____

Contract/ID/ACCT # _____ Group Number: _____

If Other Than Self:

Policy Holder's Name: _____ Relationship: _____

Date of Birth: _____ Social Security #: _____

Is this Workman's Compensation? Yes/ No Date of Injury and Person to Contact _____

Is this the Result of an Auto Accident? Yes / No Date of Injury and Person to Contact _____

With Whom May We Discuss Your Medical Condition With? (I.E. a spouse, child, parent, sibling, or guardian)

_____

I authorize the release of any medical information necessary to process claims and authorize payment of benefits to Barbara M. Kuczynski, M.D. Advanced Ophthalmology Associates PLC. I understand I am responsible for any unpaid balance remaining on my account after insurance payment or in the case of insurance rejection.

Patient Signature: _____Date:_____

Advanced Ophthalmology Associates PLC

Medical Questionnaire

Race: __ American Indian or Alaska Native __ Asian __ Black or African American
__ Native Hawaiian or Other Pacific Islander __ White

Ethnicity: __Hispanic __Not Hispanic

Preferred Language: __English Other:_____

Allergies:	**Reaction**	**Severity**
_____	_____	mild / moderate / severe
_____	_____	mild / moderate / severe
_____	_____	mild / moderate / severe
_____	_____	mild / moderate / severe

Past Ocular History: (Please mark all that apply) __No history of eye problems

__ Cataracts
__ Diabetic Retinopathy
__ Dry Eyes
__ Glaucoma
__ Hyperopia (Far sighted)
__ Iritis
__ Keratoconus
__ Macular Degeneration
__ Myopia (Near sighted)
__ Optic Neuritis
__ Retinal Detachment
__ Amblyopia (Lazy eye)
__ Aphakia
__ Astigmatism

Other_____

Ocular Surgeries: (Please mark all that apply) __No prior ocular surgery

R - L	**R - L**	**R - L**	**R - L**
__ __ Foreign Body Removal	__ __ Punctal Plugs	__ __ Laser	__ __Cataract Surgery
__ __ Blepharoplasty	__ __ Retinal Laser Surgery	__ __ RK	__ __ LASIK
__ __ Strabismus Surgery	__ __ Vitrectomy	__ __ Corneal Transplant	__ __ PRK

Other_____

Current Eye Medications: (Please list)

_____ _____ _____
_____ _____ _____

Other Medical History: ____ No history of illnesses

__ Thyroid Disease
__ Anemia
__ Arthritis
__ Arrhythmia
__ Asthma
__ Cancer
__ Hepatitis A / B / C
__ Herpes Simplex
__ Congestive Heart Failure
__ COPD
__ Diabetes Type 1
__ Diabetes Type 2
__ Eczema
__ Hearing Loss
__ Herpes Zoster / Shingles
__ Histoplasmosis
__ Syphilis
__ Headache
__ High Blood Pressure
__ High Cholesterol
__ HIV/ AIDS
__ Kidney Disease
__ Kidney Stones
__ Liver Disease
__ Meningitis
__ MRSA
__ Lung Disease
__ Lupus
__ Migraine
__ Psychiatric Disorder
__ Skin Cancer
__ Stroke
__Toxoplasmosis

Other_____

Have you had the Influenza vaccine? Yes___ No___ Or the Pneumococcal vaccine? Yes___No___

General Surgeries / Operations: (Please list)

_____ _____ _____
_____ _____ _____
_____ _____ _____

All medications with dosages including supplements: (Please list or give list to front desk to make a copy)

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Family History: Please fill with abbreviations: GGP= Great Grand Parent, GP=Grand Parent, P=Parent, A=Aunt, U=Uncle, S=Sibling, C=Child

__ Arthritis
__ Blindness Reason:_____
__ Cancer
__ Cataracts
__ Diabetes
__ Glaucoma
__ Heart Disease
__ High Blood Pressure
__ Kidney Disease
__ Lazy Eye
__ Macular Degeneration
__ Retinal Disease
__ Stroke
__ TB

Other_____

Social History: (Please mark all that apply)

Smoking: __ current every day smoker __ current some day smoker __ former smoker/quit year____ __ never smoked

Alcohol Use: __ Yes __ No If yes, how much and how often?_____

Drug Use: __ Yes __ No If yes, what drug and how often? _____

Review of Systems: (Please mark all that apply)

Eyes
__ Previous Surgery
__ Pain
__ Double Vision
__ Glaucoma
__ Cataracts
__ Macular Degeneration
__ Dry Eyes
__ Flashes
__ Floaters

Ear, Nose, and Throat
__ Hard of Hearing
__ Ringing in Ears
__ Vertigo

Cardiovascular
__Chest Pain
__Dizziness
__Fainting Spells
__Shortness of Breath
__Irregular Heart Beat
__Difficulty Lying Flat

Constitutional
__Fatigue / Weakness
__Fever
__Weight Gain / Loss

Respiratory
__Cough
__Congestion
__Wheezing
__Asthma

Gastrointestinal
__Heartburn
__Nausea /Vomiting
__Jaundice/Hepatitus

Genito-Urinary
__Pain / Difficulty
__Blood in Urine
__History of Kidney Stones
__History of STD's

Psychiatric
__Anxiety Depression
__Mood Swings
__Difficulty Sleeping

Endocrine
__Increased Thirst
__Increased Hunger
__Increased Urination
__Increased Sweating
__Fingernail Changes

Blood / Lymphnodes
__Easy Bruising
__Gums Bleed Easy
__Prolonged Bleeding
__Heavy Aspirin Use

Muscular/Skeletal
__Stiffness
__Arthritis
__Joint Pain / Swelling

Skin
__Rash / Sores
__Lesions
__Hives / Eczema

Neurological
__Seizures
__Weakness / Numbness
__Tremors

Immunologic
__Hives
__Itching
__Runny Nose
__Sinus Pressure

Office use only

History Reviewed. ☐ No Change ☐ Additions As Noted Below

_____

Physician's Signature:_____ Date :_____