Harry H. Huang, MD, PA
Ophthalmology and Ophthalmic Surgery

Today's Date: ___ /___ /_____

Patient Information

Patient Name_____Sex_____ DOB (M/D/Y) ___ /___ /_____

Address_____ City _____ State_____ Zip_____

Home Phone (___)_____ Work Phone (___)_____ Cell Phone (___)_____

Email _____ SSN_____

Occupation/Student_____ Patient's Employer_____

Ethnicity/Race_____ Preferred Language (if non English)_ _____

Name of Financially Responsible Party (if not self): _____

Address_____ City _____ State_____ Zip_____

DOB (M/D/Y) ___ /___ /_____ SSN_____ Email _____

Home Phone (___)_____ Work Phone (___)_____ Cell Phone (___)_____

Primary Insured (Subscriber): Self ( ) Spouse ( ) Parent ( ) Other _____

Subscriber's Name_____ Sex_____ DOB (M/D/Y) ____ /_____ /_____

Address_____City_____State_____Zip_____

Subscriber SSN_____

Primary Insurance_____ ID#_____ GRP#_____

Secondary Insurance_____ ID#_____ GRP#_____

Other Insurance_____ ID#_____ GRP#_____

Worker's Comp: Workers Comp Insurance_____ Claim#_____

Date of Injury ___ /___ /_____Case Worker_____ Phone (___)_____

Auto accident: Date of Accident ___ /___ /_____ Name of Attorney_____ Phone (___)_____

Referred by: _____ Phone (___)_____ Address_____

Emergency Contact Person and Relation to Patient: _____ Phone (___)_____

Privacy Policy:

The office's HIPAA privacy policy is posted and a copy is available for review. It contains important information regarding the use and disclosure of your healthcare information.

I have been notified of the office policy regarding the use and disclosure of my health information.

Patient Signature:_____

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Insurance Participation:

The Office of Harry H Huang, MD, PA is a Participating Provider with the following insurances only:

1. **Medicare (Standard and Railroad Retirement Medicare only)**
2. **Carefirst /Blue Cross Blue Shield of the National Capital Area (PPO only)**

This office is NOT a Participating Provider with any HMO plans, including Blue Choice (the Carefirst HMO as well as any Medicare HMO Plans), with any Vision/Optical Plans, with Medicaid or with ANY other commercial carriers, including Aetna, Cigna, Kaiser, and United Healthcare.

If you have insurance coverage with a carrier with which we do not participate, but you have out-of-network benefits which allows you to receive some reimbursement when you see a non-participating provider, some or all of your charges at our office may be covered by your insurance. We will be happy to submit these claims for you, but any co-pay should be paid at the time of your visit and you will be responsible for the full amount of the entire outstanding balance (including any non-covered charges), without adjustment, after the claim is processed. If you have an HMO plan or do not have any out-of-network benefits, you will be responsible for all charges at the time of your visit. All referrals and pre-authorizations required by insurance are the responsibility of the patient. We do not submit to Vision Plans. If you have any questions about insurance participation and coverage, please be sure to inquire with our staff prior to the time that you are seen.

I understand the above policy regarding insurance participation.

Patient Signature:_____

Refraction Charge:

Refraction is the optical determination of the best eye vision and is a necessary part of an ophthalmic examination. While necessary in order to prescribe glasses, it is also often needed to determine if any medical optical or surgical treatment may be indicated. Most major insurance companies including Medicare DO NOT cover the cost of a refraction regardless of the reason it is performed. The fee for a refraction is $45. Every new patient, patients returning for routine exams, patients needing a new glasses prescription, contact lens wearers, and patients following surgery, including cataracts, should expect to have a refraction done. The fee for a refraction is $45 and the patient is responsible for this fee. We do NOT participate in any Vision Plans through any insurance carriers that may cover this refraction charge.

I understand the above policy regarding the charge for refractions..

Patient Signature:_____

E-Prescribing:

E-Prescribing is available for patients who would like us to electronically send in their medical prescriptions to their pharmacy. This will make ordering prescriptions faster and easier by sending the order directly to the pharmacy from our office for the patient. F you would like to use E-Prescribing, fill-out the authorization below, along with your signature and today's date.

I would like to use E-Prescribing for my prescriptions: (circle one) YES NO

If yes, please give us your pharmacy information:

Pharmacy Name_____ Address_____

City_____ State_____ Zip Code_____ Tel No. _____

Patient Signature:_____

Insurance Authorization and Assignment of Benefits:

I request that payment of authorized Medicare/Other Insurance company benefits be made on my behalf to Harry H Huang, MD, PA for any services furnished to me by Harry H Huang, MD. I authorize the holder of medical information about me to release any information needed to determine the benefits payable for related services to the Health Care Financing Administration and its agents or my Insurance Company.

Patient Signature/Guardian: _____ Date:_____

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New Patient Medical History Form

_____ M F _____ _____

Patient's Name Sex Date of Birth Today's Date

Primary Care Physician: _____

Referring Physician: _____

Reason for your visit today: _____

Current Eye Conditions:

- ☐ Cataracts
- ☐ Glaucoma
- ☐ Retinal Please specify: _____
- ☐ Other: _____

Current Medical Conditions:

- ☐ Alzheimer's and/or Dementia
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Cancer
  Type:_____
- ☐ Cardiovascular Disease
- ☐ Depression
- ☐ Diabetes
- ☐ GERD (gastroesophageal reflux disease)
- ☐ Hyperlipidemia (high cholesterol)
- ☐ Hypertension (high blood pressure)
- ☐ Kidney Disease
- ☐ Lung Diseases (including COPD)
- ☐ Myocardial Infarction
- ☐ Parkinson's Disease
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Stroke
- ☐ Thyroid Disorders
- ☐ Other:_____

_____

Surgeries (systemic and ocular) and/or recent hospitalizations: _____

_____

Medications (name & dosage):

_____

_____

_____

Do you have any drug allergies? NO YES: _____

Do you or did you smoke tobacco? NO YES QUIT: _____

Do you drink alcohol? NO YES

Family History: Please list any medical and/or ocular diseases that any immediate family member has been diagnosed and/or treated for.

_____

_____