Western Maryland Eye Center

Date:_____ Account:_____

Patient Information

First name: _____ M.I.____ Last name:_____

Mailing address: _____ Apt:_____

City:_____ State:_____ Zip code:_____

Date of birth: _____ Marital Status: _____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Primary doctor: _____ Email:_____

Preferred language:_____ Ethnicity: Hispanic/Not Hispanic or Latino (Circle one)

Race: American Indian, Alaska native, Asian, African American, Native Hawiian, White, Other (Circle One)

Patient Employer: _____ Phone:_____

Employer address: _____

Is patient a minor? Yes/No If so, Legal guardians name and relationship: _____

Does patient have a Power of attorney? Yes/No Name of POA: _____

Emergency contact information

Name: _____ Phone:_____

Relationship: _____ Address:_____

Insurance Information

Name of Primary Insurance Company: _____ Employer:_____

Name of Insured Member: _____ D.O.B._____ SS#_____

Name of Secondary Insurance Company:_____ Employer:_____

Name of Insured Member: _____ D.O.B._____ SS#_____

Electronic Prescription/Medication History Authorization

___ I authorize Western Maryland Eye Center to electronically submit any medical prescriptions necessary to my preferred pharmacy. I also authorize Western Maryland Eye Center to obtain my medication history from this pharmacy.

Pharmacy Name:_____ Location:_____

-OR-

___ I choose not to have my medications sent electronically to the pharmacy by Western Maryland Eye Center.

Acknowledgement of Responsibility and Consent

- I certify that the information I have provided regarding my insurance coverage is correct and authorize Western Maryland Eye Center, Philip J. McGann, M.D., P.A to verify insurance coverage and benefits in accordance with my insurance plan policies.
- I authorize that payments be made directly to Western Maryland Eye Center, Philip J. McGann, M.D., P.A. for all medical insurance benefits which are payable under the terms of my policy for services provided.
- I understand that any copayments, coinsurances or deductibles are contracted between and my insurance company and myself and that I am obligated to pay them in accordance with my insurance policy.
- I agree to accept full financial responsibility for payment if my insurance has been terminated or is not in effect for the dates services are rendered.
- I agree to pay any services provided to me which are considered non-covered under my insurance plan.
- I hereby authorize Western Maryland Eye Center, Philip J. McGann, M.D., P.A. to submit claims to my insurance companies, including Medicare and Medicaid for all services. This authorization also allows for submission of medical records requested by the insurance company.
- I authorize Western Maryland Eye Center, Philip J. McGann, M.D., P.A. to release information about my medical care to my primary care physician to assist in the continuity of my medical health care.

Self Pay Patients

- I do not have insurance coverage or do not want the services provided submitted to my insurance company. I understand that payment for services under these conditions are my sole responsibility.

Authorization for protected health information on voicemail

___ Yes, I authorize Western Maryland Eye Center to leave protected health information as a message on my answering machine or voicemail.

___ No, I do NOT authorize Western Maryland Eye Center to leave protected health information on my answering machine or voicemail.

Signature of patient, POA or Legal Guardian Date

WESTERN MARYLAND EYE CENTER

PHILIP J. McGANN, MD, PA
1123 W. Steuart St., #400
Fredericksburg, VA 22401
Phone # 540-752-3720
Fax # 540-752-5662

MEDICAL HISTORY QUESTIONAIRRE

PATIENT NAME:_____DATE:_____ACCT. #:_____

PLEASE LIST ALL MEDICATIONS YOU TAKE, BOTH PRESCRIPTION AND OVER THE COUNTER, INCLUDING VITAMINS: (If you brought a list with you today, please hand to the front desk with this form and you can skip this section of the questionnaire)

NAME OF MEDICATION DOSAGE FREQUENCY

_____

_____

_____

_____

_____

_____

DO YOU HAVE ANY KNOWN ALLERGIES TO MEDICATIONS? YES / NO

IF YES, PLEASE LIST THE MEDICATION AND THE ADVERSE REACTION:

_____

_____

PLEASE LIST ANY SURGERIES YOU HAVE HAD

_____

_____

FAMILY HISTORY : HAS ANY MEMBER OF YOUR FAMILY HAD ANY OF THE FOLLOWING? (CIRCLE ALL THAT APPLY)

Blindness, Macular Degeneration, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis, Kidney Disease, Lupus, Cancer

Other:_____

HAVE YOU BEEN DIAGNOSED WITH ANY DISEASES OR CHRONIC ILLNESSES? IF SO, LIST THEM HERE:

_____

_____

_____

Outcome PQRS Patient ID: _____ Practice/Surgeon's Name: _____

Site ID as seen in PQRS Registry: _____

Pre-Surgery Visual Functioning VF-8R Patient Questionnaire

Do you have difficulty, even with glasses with the following activities?

1. Reading small print such as labels on medicine bottles, a telephone book or food labels?	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A Little ☐ A Moderate Amount ☐ A Great Deal ☐ Unable to do the activity
2. Reading a newspaper or book?	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A Little ☐ A Moderate Amount ☐ A Great Deal ☐ Unable to do the activity
3. Seeing steps, stairs or curbs?	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A Little ☐ A Moderate Amount ☐ A Great Deal ☐ Unable to do the activity
4. Reading traffic signs, street signs or store signs?	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A Little ☐ A Moderate Amount ☐ A Great Deal ☐ Unable to do the activity
5. Doing fine handwork like sewing, knitting, crocheting or carpentry?	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A Little ☐ A Moderate Amount ☐ A Great Deal ☐ Unable to do the activity
6. Writing checks or filling out forms?	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A Little ☐ A Moderate Amount ☐ A Great Deal ☐ Unable to do the activity
7. Playing games such as bingo, dominos, card games or mahjong?	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A Little ☐ A Moderate Amount ☐ A Great Deal ☐ Unable to do the activity
8. Watching television?	☐ Yes ☐ No ☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A Little ☐ A Moderate Amount ☐ A Great Deal ☐ Unable to do the activity