AZAR EYE INSTITUTE
See Your Future with Clarity
SALISBURY: 410-546-2500 | LAUREL: 302-875-8991

Dear Patient,

Welcome to our practice!

Attached are some forms we would like you to fill out and bring with you on the day of your appointment. Please do not mail them back to us because we have no where to store them prior to your appointment.

On the day of your appointment, please also bring your insurance cards, photo ID, and referral if your insurance requires one. All co-pays are due at the time of check out. We accept cash, check or credit card except for American Express.

Since there is a possibility that your eyes will be dilated, we strongly recommend that you bring a driver with you.

If the patient is under the age of 18, a parent must accompany the minor. If the parent cannot attend, another adult can accompany the minor if they provide **written** permission from the parent. The permission must state that it is okay for this adult to bring the child and for us to examine and treat the child as necessary.

If you are unable to keep your appointment, kindly give us 24 hours notice.

Thank you for choosing our practice. We look forward to seeing you!

Azar/Filipov, MD, PA

Please Print Clearly

■ Patient Information

Name **(Last, First, Middle)** ______________________ Today's Date ______________

Birthdate ____________ **Soc. Sec. #** ____________ **Home Phone** ______________

Email address ______________________ Cell Phone ______________

Address ______________________ Work Phone ______________

City ____________ **State** ________ **Zip** ________ **Sex:** ☐ M ☐ F

☐ Check if Minor (less than18) **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If under 18, list parents or guardians' names ______________________

Person to contact if unable to reach you & phone # ______________________

Person responsible for bills ______________________

Referring Physician ______________________ Phone ______________

■ Primary Insurance

Insurance Company ______________________

Insurance ID # ______________________ **Group #** ______________

Please enter the policyholder's information below. If you are the policyholder yourself, check this box ☐ and skip to the next section.

Policyholder's Name (Last, First, Middle) ______________________

Relationship to Patient ________ **Soc. Sec. #** ____________ **Birthdate** ______________

■ Secondary Insurance *(If not applicable, please cross out section. If you have tertiary insurance, please ask the receptionist for another page.)*

Insurance Company ______________________

Insurance ID # ______________________ **Group #** ______________

Please enter the policyholder's information below. If you are the policyholder yourself, check this box ☐ and skip to the next section.

Policyholder's Name (Last, First, Middle) ______________________

Relationship to Patient ________ **Soc. Sec. #** ____________ **Birthdate** ______________

■ Is today's visit related to an accident?

__Yes __No If yes, what type of accident (Auto, Employment, Other) ______________________

When did the accident occur? Date and Time ______________

■ Assignment and Release

I hereby authorize payment directly to Azar/Filipov, MD, PA of all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered for me or for my dependents. I authorize the doctors and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of my signature on all insurance submissions. I authorize a copy of this document to be used in place of the original. I have read and agreed to the above.

■ Consent

I consent to and authorize the administration of all routine office care; the performance of all examinations; diagnostic procedures and medical treatment, which judgment of my attending physician(s) may be necessary or desirable for my medical care.

Signature: ______________________ Date: ______________

If the patient is a minor (under 18 years of age), the responsible parent or guardian must sign above, and fill in the information below.

Parent/Guardian Name (print): ______________ Relationship to Patient: ______________

Account #: ________

MEDICAL HISTORY QUESTIONNAIRE

Name: ______________________ Date of Birth: __________ Family Physician: ________________

Date: __________ Date of **last eye exam**: __________

List any **medications** you are currently taking (Rx and over-the-counter): ____________

____

____

Do you have **allergies** to any medications? **YES** **NO**

If YES, list the medications: ______________________________

List all **major illnesses** (glaucoma, diabetes, high blood pressure, heart attack, etc.) or **injuries** (concussion, etc.): ______________________________

List any **surgeries** you have had (cataract, appendectomy): ______________________________

Do you ***currently*** have any problems in the following areas? If YES, please provide additional information.

	YES	NO	Details
EYES (poor vision, eye pain, tearing, redness, etc.)			
GENERAL/CONSTITUTIONAL (fever, heat stroke, weight loss, weight gain, unusually tired)			
EARS, NOSE, THROAT (hard of hearing, stuffy nose, earache, cough, dry mouth, etc.)			
CARDIOVASCULAR (high BP, racing pulse, etc.)			
RESPIRATORY (congestion, wheezing, short of breath, etc.)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)			
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, yellow jaundice, etc.)			
FEMALES Are you pregnant? Nursing?			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
SKIN (pimples, warts, growths, rash, etc.)			
NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD/LYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)			
ALLERGIC/IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)			

FAMILY HISTORY (Mother, Father, Grandparent, Sibling)

Has any member of your family had these diseases (circle all that apply)? **YES** **NO** **UNKNOWN**

Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis

Other heritable disease: ______________________________

SOCIAL HISTORY

Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)? **YES** **NO**

Have you ever had a blood transfusion? .... **YES** **NO**

Do you drink alcohol? ....**YES** **NO** If YES, how much? __________

Do you smoke? ....**YES** **NO** If YES, how much? __________ How many years? __________

Physician's Signature ______________________ *Date* __________