

**PATIENT INFORMATION FORM**  
**Fante Eye & Face Centre**

Patient Name \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell/Pager \_\_\_\_\_

Email address: \_\_\_\_\_ Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_ Gender  F  M

Marital Status  Single  Married  Partner  Divorced  Widowed  Other \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Work Phone \_\_\_\_\_

Parents' Names (if child) \_\_\_\_\_ Work Phone \_\_\_\_\_

Pharmacy \_\_\_\_\_ Phone \_\_\_\_\_ Address \_\_\_\_\_

**INSURANCE INFORMATION**

Primary Insurance \_\_\_\_\_

Subscriber Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Secondary Insurance \_\_\_\_\_

Subscriber Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Are you currently employed? Y N Is your spouse or other family member employed? Y N

Have you ever served in the military? Y N Are you here for an injury from work? Y N

Do you have secondary insurance? Y N Are you covered under any other healthcare plan? Y N

Are your injuries accident related? Y N Are you covered under an employer? Y N

**REFERRAL INFORMATION**

Who sent you to our office? \_\_\_\_\_ Reason for appt \_\_\_\_\_

**PHYSICIAN INFORMATION**

General Doctor \_\_\_\_\_ Telephone \_\_\_\_\_

Ophthalmologist \_\_\_\_\_ M.D. Telephone \_\_\_\_\_

Optometrist \_\_\_\_\_ O.D. Telephone \_\_\_\_\_

Other Specialist Doctors (cardiology, endocrine, cancer, plastic surgery, etc):

Name \_\_\_\_\_ Specialty \_\_\_\_\_ Telephone \_\_\_\_\_

Name \_\_\_\_\_ Specialty \_\_\_\_\_ Telephone \_\_\_\_\_

**EMERGENCY INFORMATION**

Person to Notify \_\_\_\_\_

Relationship to you \_\_\_\_\_ Telephone \_\_\_\_\_

# Confidential Medical History Form

## Fante Eye & Face Centre

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

**1. Please list all medications you take on a regular basis:**

(Please include any eye drops, vitamins, herbs, or over the counter products such as aspirin or aspirin containing products.)

<u>Medication</u>	<u>Strength</u>	<u>Frequency</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____

**2. Please list all illnesses/diseases which you have had or have now:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_

**3. Please list all prior surgeries or procedures:**

<u>Surgery</u>	<u>Physician</u>	<u>Approximate Date</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

**4. Please list any allergy or sensitivity to medication or food:**

<u>Medication</u>	<u>Reaction</u>
1. _____	_____
2. _____	_____
3. _____	_____

Patient Name: \_\_\_\_\_

**5. Has anyone in your family had the same problem that brings you to our office?**

Yes  No If yes, who? \_\_\_\_\_

**Do any of these diseases run in your family. If YES, please note relationship** \_\_Glaucoma

Do you smoke? If YES, how much? \_\_\_\_\_

\_\_Diabetes \_\_\_\_\_  
\_\_High blood pressure \_\_\_\_\_  
\_\_Skin cancer \_\_\_\_\_  
\_\_Other \_\_\_\_\_

Drink alcohol? If YES, how much? \_\_\_\_\_

**6. Do any of the following problems apply to you? If YES, please explain.**

<b>Constitutional</b> (fever, weight loss, poor appetite, etc.)	<input type="checkbox"/> yes <input type="checkbox"/> no	
<b>Eyes</b> (glaucoma, cataract, lazy eye, retina problems, etc)	<input type="checkbox"/> yes <input type="checkbox"/> no	
<b>Ear/Nose/Throat</b> (hearing loss, sinus problems, sore throat, frequent bloody noses, etc)	<input type="checkbox"/> yes <input type="checkbox"/> no	
<b>Cardiovasc</b> (heart problems, chest pain, high blood pressure, stroke, pacemaker, heart surgery)	<input type="checkbox"/> yes <input type="checkbox"/> no	
<b>Respiratory</b> (asthma, shortness of breath, wheezing, coughing, etc)	<input type="checkbox"/> yes <input type="checkbox"/> no	
<b>Gastro-intestinal</b> (heartburn, diarrhea, vomiting, abdominal pain, etc)	<input type="checkbox"/> yes <input type="checkbox"/> no	
<b>Genito-urinary</b> (urinary problems, blood in urine, etc)	<input type="checkbox"/> yes <input type="checkbox"/> no	
<b>Skin</b> (skin rashes, excessive dryness, used accutane, skin cancer/diseases, etc)	<input type="checkbox"/> yes <input type="checkbox"/> no	
<b>Musculoskeletal</b> (muscle aches, joint pain, swollen joints, artificial joint, arthritis, etc)	<input type="checkbox"/> yes <input type="checkbox"/> no	
<b>Neurological</b> (numbness, weakness, paralysis, headaches, spasm, MS, etc)	<input type="checkbox"/> yes <input type="checkbox"/> no	
<b>Hematologic</b> (blood disorders, leukemia, easy bleeding/bruising, take aspirin, etc)	<input type="checkbox"/> yes <input type="checkbox"/> no	
<b>Allergy</b> (hay fever, seasonal allergies, etc)	<input type="checkbox"/> yes <input type="checkbox"/> no	
<b>Endocrine</b> (thyroid or pituitary problems, etc)	<input type="checkbox"/> yes <input type="checkbox"/> no	
<b>Psychiatric</b> (depression, anxiety, etc)	<input type="checkbox"/> yes <input type="checkbox"/> no	
Hepatitis B or C, HIV or AIDS, Tuberculosis, etc	<input type="checkbox"/> yes <input type="checkbox"/> no	
Diabetes, radiation treatments, anesthesia problems, etc.	<input type="checkbox"/> yes <input type="checkbox"/> no	

Other Comments: \_\_\_\_\_

Physician Initials \_\_\_\_\_ Date \_\_\_\_\_

**Fante Eye & Face Centre**  
**3900 East Mexico Avenue, Suite 510**  
**Denver, CO 80210**

## **NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, and read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address listed above to obtain a current copy of the Notices of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I approve the following people to discuss my medical records & care with Fante Eye & Face Centre:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Date: \_\_\_\_\_

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### **FOR OFFICE USE ONLY**

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: \_\_\_\_\_ Initials: \_\_\_\_\_ Reason: \_\_\_\_\_

**FANTE EYE & FACE CENTRE**  
**3900 E Mexico Ave • Suite 510**  
**Denver, CO 80210**

**FINANCIAL POLICIES**

Payment is expected at the time of service for all non-contracted fees. Arrangements must be made with our office manager prior to seeing the physician if an account balance is anticipated. I understand that I am financially responsible for all charges whether or not covered by insurance.

**PRIVATE INSURANCE**

All private health insurance plans represent a contract between you and the insurance company. These contracts are not between the physician and the insurance company. As a courtesy, we will bill your insurance for all services rendered, but we are not responsible if your insurance does not pay. Instead, it is your responsibility to make certain that your insurance makes prompt payment, and to handle any disputes or questions that may arise.

\_\_\_\_ *(initial)* **If you have not yet met your deductible, there is a \$500 deposit due upon scheduling surgery.**

\_\_\_\_ *(initial)* **If you cancel a medical surgery within two weeks of the scheduled date, you will owe a \$500 cancellation fee. Insurance will not cover this fee.**

**INSURANCE CONTRACTS**

If we participate with your insurance carrier, we will accept assignment on all covered services and bill your insurance for you. You are responsible for the copay, deductible, and all non-covered services. Depending upon your particular benefits package with your insurance, they may cover some, all, or none of the services rendered to you.

Therefore it is your responsibility to:

1. Provide documentation of your coverage
2. Know what benefits are covered by your insurance and what services are your personal responsibilities.
3. Provide the appropriate documents (e.g. referrals) that allow us to bill your insurance carrier. If the appropriate information is not received, you will be asked to sign a waiver of responsibility.

**MEDICARE**

We accept Medicare assignment, which means that we accept the allowable charges set by Medicare. Medicare typically pays 80% of the allowable charge after your deductible has been met. You will be responsible for the 20% remainder unless you have a Medicare supplement. We will bill your Medicare supplement after Medicare has paid, if you provide the necessary information to us.

**COSMETIC REVISIONS**

Rarely, after complete healing from surgery for which insurance has paid, you and your surgeon may agree that some revision procedure would enhance your cosmetic outcome. I understand that aesthetic surgery is not a covered benefit of Medicare and other insurance carriers. Therefore any aesthetic procedure will be my financial responsibility and payment in full will be expected prior to the procedure.

**MEDICAL AUTHORIZATION RELEASE**

By signing below, you authorize Robert G. Fante, M.D. or Michael J. Hawes, M.D. to give you reasonable and proper medical care by today's standard.

I agree that the attending physician may use, or permit other persons to use any negatives, prints, movies, and digital images, and/or other visual or audio recordings, for purposes including, but not limited to, dissemination to health care professionals and/or members of the public for treatment, research, medical, scientific, teaching, or other purposes in such a manner as may be deemed appropriate by my attending physician. I agree that this information may be disseminated in either paper form or digital form using delivery techniques that include but are not limited to the U.S. Postal Service, Federal Express, UPS, email, the Internet, and file transfer protocol.

I hereby authorize Robert G. Fante, M.D. or Michael J. Hawes, M.D. to release any medical or other necessary information to insurance carriers in either paper or digital form concerning this illness/accident. I hereby irrevocably assign all payments for all services rendered to Dr. Robert Fante or Dr. Michael Hawes. I also request payment of government benefits either to myself or to Robert G. Fante, M.D. or Michael J. Hawes, M.D. I have read and understand the policies described above. I have provided complete and accurate medical and financial information on all forms. I acknowledge that I am responsible to pay all charges for treatment as outlined above.

A copy of this authorization shall be considered valid as the original.

\_\_\_\_\_  
Patient Signature/Responsible party      Date