To Our Patient:

We welcome you to our practice and look forward to seeing you at the time of your scheduled appointment. For your first visit please arrive 15 minutes earlier than your scheduled time.

Please bring to your appointment:

- The attached forms completed, signed and dated
- List of medications and allergies
- Any correspondence from your referring physician (if applicable)
- Any test results pertaining to your visit – such as CT Scan, MRIs (if applicable)
- Insurance cards (primary and secondary insurance)
- Co-pay for visit (if applicable)
- Referral (if applicable) – Our office does have access to retrieve referrals electronically.
- Photo identification (drivers license).

Below find a list of provider numbers:

Aetna Provider #1396731501
Amerihealth Provider #1396731501
Horizon Blue Shield Provider #231878228
Keystone Provider #1396731501
Keystone Mercy Provider #45195

We do accept most insurance plans although **WE DO NOT ACCEPT CIGNA HEALTHSPRINGS**

We Accept Visa, Mastercard, Discovery and American Express for your convenience.

If you are being seen for a **COSMETIC CONSULT** you will be charged $150.00 at the time of your visit.

If you have any questions regarding your appointment, please contact our office at 610-649-1970 or visit our website **wwwphillyeyeplastics.com** for more information about our practice.

On the reverse side you will find information for our various office facilities.

Yours truly

Dr. Flanagan, Dr. Stefanyszyn, Dr. Penne, Dr. Carrasco, Dr. Rabinowitz, and Dr. Sergott

Lankenau Office - 100 E. Lancaster Ave, Suite 54 MOB East, Wynnewood, PA 19096

Route 30 (Lancaster Ave) west of City Line Ave (Route 1). Follow signs to the visitors Parking Garage "B". When you exit the garage continue through the covered walkway to the second building (East Building). Lankenau Hospital does offer valet parking at the main entrance.

Discounted parking is available at Lankenau Hospital parking garage for Senior Citizens only.

Wills Eye Hospital Office - Walnut Towers, 840 Walnut St, Suite 910, Philadelphia, PA 19107

Entrances are between Locust & Walnut and on Walnut Street between 8th & 9th.

Discounted parking is available at Wills Eye Hospital parking garage.

Marlton Office (Dr. Penne and Dr. Rabinowitz only)-

Elmwood Business Park, 775 Route 70 East, Suite F180, Marlton NJ 08053 -- If using a GPS please put in **EVESHAM TOWNSHIP**

Galloway Office - (Dr. Carrasco only)-

4 East Jimmy Leeds Road, Suite 2, Galloway Township, NJ 08205

Tamaqua Office (Dr Rabinowitz only) -

Mahoning Valley Eye Center, 37 Medical Crossing, Tamaqua, PA 18252

ANNESLEY, FLANAGAN, STEFANYSZYN, PENNE & ASSOCIATES Patient Registration Forms

100 East Lancaster Avenue, MOB East, Suite 54 Wynnewood, PA 19096 610-649-1970

PATIENT INFORMATION

Patient Information:

Last Name:	First Name: M.I.:	Previous Name *(If applicable)*
Mailing Address:		
City/State/Zip:		
Home Phone:	Cell Phone:	Work Phone:
Which above phone number can we leave a detailed message on?		If voice, please select Preferred Number: ☐ Home ☐ Cell ☐ Work
Date of Birth:		Sex: ☐ Male ☐ Female
Marital Status:		Social Security #:
Occupation:	Emergency Contact Name:	Relationship to Patient:
Emergency Contact Phone #:	May we share your Patient Information with your Emergency Contact? ☐Yes ☐ No	

ADDITIONAL INFORMATION

Additional Information (*PLEASE FILL OUT ALL SECTIONS BELOW*)

Referring Physician	Address and Phone Number:
Primary Physician:	Address and Phone Number:
Pharmacy Name & Location:	Pharmacy Phone Number:
Race *(please select)*: ☐ White ☐ Black or African American ☐ American Indian ☐ Asian ☐ Hispanic ☐ Native Hawaiian or Pacific Islander ☐ Other ☐ Decline	Ethnicity *(please select one)*: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline
Preferred Language:	EMail:

INSURANCE INFORMATION

Primary Medical Insurance	Secondary Medical Insurance
Insurance Company Name:	Insurance Company Name:
Policy Holder Name:	Policy Holder Name:
I.D. Number:	I.D. Number:
Group Number:	Group Number:
Is Today's Visit Accident or Work Related? ☐ Yes ☐ No	Claim #
Workman's Comp. / Auto Insurance Name, Address, and Phone #	

INSURANCE AUTHORIZATION AND ASSIGNMENT

I understand and agree that Annesley, Flanagan, Stefanyszyn, Penne & Associates (AFFS) and its employees and agents may use and disclose protected health information about me for payment, treatment, and/or health care options. I request that payment of authorized insurance benefits be made either to me or on my behalf to AFFS for any services furnished to me by AFFS and its employees and agents. I authorize any holder of medical information about me to release to the insurance company and its agents any information needed to determine these benefits or the benefits payable for related services.

PHOTOGRAPH AUTHORIZATION

I hereby authorize Annesley, Flanagan, Stefanyszyn, Penne, & Associates and their colleagues to take photographs of me while undergoing medical and ophthalmic testing and surgery. These photographs may be used for teaching purposes; they will not be shown to the public or media without my express consent.

HIPPA

I have received/reviewed a copy of Annesley, Flanagan, Stefanyszyn, Penne, & Associates Notice of Privacy Practices.

Signature of Responsible Party:______________________________ Date:______________________

Printed Name of Responsible Party: ______________________________ Date:______________________

New Patient Medical History Form

Name: ______________________________ **Date of Birth:** ___________________

Height: _____ft_____in **Weight:** _____ **Occupation:** _________________________

Smoker: Never Stopped: How Long Ago?_____ Yes: How Long?_____, How Many? _____
Alcohol Use: Frequent Occasional Never
Drug Use: Frequent Occasional Never Substance_____________

Present Complaint:____

____

Ocular History:____

____

Medications: Please list all of your current medications on the back of this form.
Allergies:____

Medical History:

High blood pressure	Y	N	High cholesterol	Y	N
Heart disease	Y	N	Gastro intestinal	Y	N
Diabetes	Y	N	Ear, nose and throat	Y	N
Cancer	Y	N	Kidney/Bladder	Y	N
Thyroid imbalance	Y	N	Pacemaker	Y	N
Arrhythmia	Y	N	Neurological	Y	N
Arthritis	Y	N	Psychiatric	Y	N
Stroke	Y	N	Pulmonary	Y	N
Congestive heart failure	Y	N	Weight Loss	Y	N

Did you have a Flu Shot? Y N Date:________ Given by: Physician/Pharmacy/Employer

Family History

		Relative			Relative
High blood pressure	Yes	__________	Glaucoma	Yes	__________
Heart disease	Yes	__________	Cornea	Yes	__________
Diabetes	Yes	__________	Cataracts	Yes	__________
Cancer	Yes	__________	Retinal	Yes	__________
Arthritis	Yes	__________	Eye Muscles	Yes	__________

Is your mother living/deceased? Is your father living/deceased?

Surgical History		**Hospitalization** (other than surgical)	
Date	Operation	Date	Reason
__________	______________________________	__________	______________________________
__________	______________________________	__________	______________________________
__________	______________________________	__________	______________________________
__________	______________________________	__________	______________________________

Please list all medications that you take (including dose and strength):

Medication	Dose	# times a day	Reason Using Medication
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			

CONSENT TO OBTAIN MEDICATION HISTORY

As a user of an electronic medical record, we would like to include your medication history in your record. A medication history is a list of prescription medicines that we or other doctors have prescribed for you. This list is collected from several sources, including your pharmacy and your health insurance.

By signing this consent form you are agreeing that your provider at Annesley, Flanagan, Stefanyszyn, Penne, Carrasco and Rabinowitz may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes. This consent will enable Annesley, Flanagan, Stefanyszyn, Penne, Carrasco and Rabinowitz to:

- Determine the pharmacy benefits and drug co pays for a patient's health plan.
- Check whether a prescribed medication is covered (in formulary) under a patient's plan.
- Display therapeutic alternatives with preference rank (if available) with a drug class for medications.
- Determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies, and if so, e-prescribe to these pharmacies.
- Download a historic list of all medications prescribed for a patient by any provider.

In summary, we ask your permission to obtain formulary information, and information about other prescriptions prescribed by other providers.

You may decide not to sign this form. Your choice will not affect your ability to get medical care, payment for your medical care, or your medical care benefits. You also have a right to receive a copy of this form after you have signed it.

This consent form will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing but if you do, it will not have an effect on any actions taken prior to receiving the revocation.

______________________________ ______________

Print Patient Name Patient's Date of Birth

______________________________ ______________

Signature of Patient or Guardian Today's Date

____

Relationship to Patient