ANNESLEY, FLANAGAN, FISCHER, STEFANYSZYN, & ASSOCIATES
dba Oculoplastic Surgeons of Philadelphia
100 Lancaster Avenue, MOB East, Suite 54 Wynnewood, PA 19096

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:

Please select preferred number ☐ Home ☐ Cell ☐ Work

Date of Birth:	Sex: Male Female
Marital Status:	Social Security #:
Occupation:	Emergency Contact Name:
Emergency Contact Phone #:	Relationship to Patient:

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, Fischer, Stefanyszyn, &Associates (AFFS) dba Oculoplastic Surgeons of Philadelphia 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, Fischer, Stefanyszyn, & Associates and their colleagues dba Oculoplastic Surgeons of Philadelphia to take photographs of me while undergoing medical and ophthalmic testing and surgery. These photographs may be used for teaching or promotional purposes.

HIPPA

I have received/reviewed a copy of Annesley, Flanagan, Fischer, Stefanyszyn, & Associates dba Oculoplastic Surgeons of Philadelphia Notice of Privacy Practices.

Signature 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

Date	Operation
_____	_____
_____	_____
_____	_____
_____	_____

Hospitalization (other than surgical)

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.			

Financial Responsibility Assignment of Benefit and

Patient Authorization

Charges for Items of Services

I am financially responsible to the extent permitted by applicable law to pay to Annesley, Flanagan, Stefanyszyn, and Penne & Associates all charges for items or services rendered to Patient. This expressly includes any insurance deductibles. Co-insurances, co-payments and non-covered services. I acknowledge that the information provided is accurate and complete. If there are any changes to this information in the future, I will provide any such changes at my next scheduled visit.

Assignment of Benefits

I hereby authorize and assign payment directly to Annesley, Flanagan, Stefanyszyn, Penne & Associates for medical insurance benefits otherwise payable to me under the terms of my policy, but not exceed the balance due to Annesley, Flanagan, Stefanyszyn, Penne & Associates for items rendered to the Patient.

Release of Health Information

I authorize Annesley, Flanagan, Stefanyszyn, Penne & Associates disclose any or all parts of Patient's medical record to the Patient's insurance company(s) or employer(s) for the purpose of satisfying charges billed by Annesley, Flanagan, Stefanyszyn, Penne & Associates for items or services provided by the Patient. I further understand that it may be necessary for Annesley, Flanagan, Stefanyszyn, Penne & Associates to contact my past or present employer regarding this claim. This authorization does not cover third party liability claims.

I hereby release and forever discharge Annesley, Flanagan, Stefanyszyn, Penne & Associates and its respective employees, directors, officers, shareholders, agents, assigns and legal representative (collectively, Annesley, Flanagan, Stefanyszyn, Penne & Associates Parties) from any and all obligations, claims, liabilities, damages, debts, liens and deficiencies arising out of or in connection with Financial Responsibility, Assignments of Benefits and Patient Authorization ("Authorization"). I hereby agree to indemnify and hold harmless Annesley, Flanagan, Stefanyszyn, Penne & Associates from and against any liability, loss, cost or expense (including reasonable attorney's fees) incurred by Annesley, Flanagan, Stefanyszyn, Penne & Associates in reliance upon this Authorization.

I permit a copy of this Authorization to be used in place of the original. I certify that this information is true complete to the best of my knowledge.

Patient Signature Date DOB

Responsible Party Name (if applicable) Date

Responsible Party Signature (if applicable) Date

Please describe responsibility Party relationship to Patient: _____

Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rules

Acknowledgement of Receipt of Notice of Privacy Practices

By signing below I acknowledge that Annesley, Flanagan, Stefanyszyn, Penne and Associates has provided me with access to its Notice of Privacy Practices, as required under the Health Insurance Portability and Accountability Act of 1996.

Charges for Items of Services

I am financially responsible to the extent permitted by applicable law to pay Annesley, Flanagan, Stefanyszyn, Penne and Associates all charges for items and services rendered to patient. This expressly includes any insurance deductibles, co-insurance, co-payments and non-covered services. I acknowledge that the information provided is accurate and complete. If there are any changes to this information in the future I will provide any such changes at my next scheduled visits.

Consent for Photography

I hereby authorize Annesley, Flanagan, Stefanyszyn, Penne and Associates and their colleagues to take the photographs of me while undergoing medical and ophthalmic testing and surgery. These photographs may be used for teaching purposes, research, and publication in a medical journal and/or for marketing purposes. They will not be shown to the public or media without my express consent. I have read and understand the foregoing and I consent to the use of my photographs as specified above.

_____ _____

Patient Signature/ or Patient's Personal Representative Date DOB