OCULOPLASTIC SURGEONS
OF PHILADELPHIA

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.
- A list of medications and allergies.
- Any correspondence from your referring physician (if applicable).
- Any test results pertaining to your visit – **such as CT scan, MRI DISC for the doctor to review (if applicable).**
- Insurance cards (primary and secondary insurance).
- Co-pay for the visit (if applicable).
- Referral (if applicable): **Our NPI# 1396731501.**
- Photo identification (driver license).

____ **Dr. Jacqueline Carrasco** ____ **Dr. Robert Penne**

____ **Dr. Michael Rabinowitz** ____ **Dr. Mary Stefanyszyn**

____ **Dr. Alison Watson**

We accept Visa, Mastercard, Discover, and American Express for your convenience.

If you are being seen for a **COSMETIC CONSULT,** you will be charged **$200.00** at the time of scheduling.

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

If you wish to email your new patient forms back to the office, our email address is: Frontdesk@phillyeyeplastics.com

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

Yours truly,
Dr. Carrasco, Dr. Rabinowitz, Dr. Watson, Dr. Penne and Dr. Stefanyszyn

____ **LANKENAU HOSPITAL** **DATE** _____

____ **CENTER CITY – CURTIS CENTER** **TIME** _____

____ **MARLTON– ELMWOOD BUSINESS PARK**

____ **MEDIA**

CLINIC DIRECTIONS

Lankenau Office – 100 Lancaster Ave, Suite 54 MOB East, Wynnewood, PA 19096

Route 30 (Lancaster Ave) west of City 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). Walk straight, up on the right are a set of escalators, to the left is the Coffee shop ATRIUM CAFÉ, we are on the left. Valet parking is offered at the main entrance of Lankenau Hospital

Curtis Center Office – 601 Walnut St, Suite L60, Philadelphia, PA 19106

Our newest location is located on the first floor of the Curtis Center.
Valet parking is available at 625 Sansom Street. You can also park at Parkway lot next to the Walnut Theater on Walnut Street (across from Wills Eye Hospital).

Marlton Office – Elmwood Business Park – 775 Route 70 East, Suite F180, Marlton NJ 08053
(Only: Dr. Penne, Dr. Rabinowitz)

Please input "Elmwood Business Park" into your GPS. The office is on the corner of North Elmwood Road and Route 70 East. We are in Building F.
Complimentary parking is available on-site.

Media Office – Ophthalmic Partners – 319 W. State St, Media Pa 19063
(Only: Dr. Watson)

Our office is located within the Ophthalmic Partners clinic.
Complimentary parking is available on-site.

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

Patient Registration Forms

610-649-1970 - Lankenau
267-928-2798 – Curtis Center

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:

DO YOU HAVE A LIVING WILL? Yes ____ or No ____

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:_____lbs Occupation:_____

Primary Ophthalmologist:_____ Do you wear prescription glasses or contact lenses? Y N

Present Complaint:_____

_____

Ocular History: Please specify right, left, or both eyes._____

_____

Allergies:_____

Medications: Please list all of your current medications on the back of this form. Please include all eye drops/ointments, including over the counter eye medications.

Medical History: Please specify when appropriate.

High Blood Pressure:	Y N	High Cholesterol:	Y N	Stroke:	Y N
Heart Disease:	Y N	Gastro Intestinal:	Y N	Glaucoma:	Y N
Diabetes:	Y N	Ear, Nose, and Throat:	Y N	Cornea:	Y N
Cancer:	Y N	Kidney/Bladder:	Y N	Cataracts:	Y N
Thyroid Imbalance:	Y N	Pacemaker:	Y N	Retinal:	Y N
Arrhythmia:	Y N	Neurological:	Y N	Eye Muscles:	Y N
Arthritis:	Y N	Psychiatric:	Y N	Dry Eyes:	Y N
Congestive Heart Failure:	Y N	Rapid Weight Loss:	Y N		

Do you have a Cardiologist? Name_____ **Phone #** _____

Are you pregnant? Y N Breast Feeding? Y N

Smoker: Never Stopped: How Long Ago? _____ Yes: How Long? _____ How many? _____

Alcohol Use: Frequent Occasional Never

Drug Use: Frequent Occasional Never Substance:_____

Have you fallen in the last year? Yes_____ or No_____ If Yes, how times_____

Family History: Please specify which Relative.

High Blood Pressure:_____ Glaucoma:_____

Heart Disease:_____ Cornea:_____

Diabetes:_____ Cataracts:_____

Cancer:_____ Retinal:_____

Arthritis:_____ Eye Muscles:_____

Is your mother living/deceased? Is your father living/deceased? Please circle.

Surgical History:

Date:	Operation:
_____	_____
_____	_____
_____	_____
_____	_____

Hospitalization: (other than surgical)

Date:	Reason:
_____	_____
_____	_____
_____	_____
_____	_____

Medication List

Please list all medications that you take (including dose and strength). Please be sure to include all eye drops/ointments, including over the counter eye medications.

Medication	Dose	# Times per 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

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: _____