New Century Ophthalmology Group, PLLC
Medical, Laser, and Surgical Eye Care

1001 College Street, Oxford, NC 27565
Phone: (919) 693-6661 Fax: (919) 690-1160

Vinod K. Jindal, MD, FACS
Board Certified Ophthalmologist and Retina Specialist

Kajal Dhebaria, OD
Optometric Physician

Yewanda O. Olagoke, OD
Optometric Physician

PATIENT NAME _____ (Please circle) **Male/Female**
Last First Middle Initial

Date of Birth _____ **Race** _____ **Marital Status** (Please circle) S / M / D / W

Mailing Address _____

City _____ **State**_____ **Zip Code**_____

Home Phone # _____ **Work/Cell #** _____ **Social Security #** _____

Email _____ **how did you hear about us?** _____

Primary Medical Doctor _____ Phone # _____
Referring Doctor _____ Phone # _____
Pharmacy_____ **Phone #** _____

Insurance
Medical:_____ **Vision:**_____
Responsible Party _____ Date **of Birth**_____ **SS#** _____
Address _____ City _____ **State** _____ **Zip** _____
Relationship: Self Mother Father Husband Wife Other: _____ **Employer:**_____

In case of emergency: Name _____ **Phone #**_____ **Relationship:**_____
If Accident related give DATE OF ACCIDENT_____

FINANCIAL RESPONSIBILITIES:
The undersigned, of the above named patient, does hereby agree to financially pay New Century Ophthalmology Group, PLLC of the medical services rendered on demand of said services and incidentals incurred on behalf of such patient.

Assignment of Insurance Benefits:
Your insurance policy is contract between you and your insurance company. We are not a party to that contract. In the event that we do accept assignment of benefits, please be aware that some, and perhaps all of the services provided may be non-covered services under your plan and in the event that your insurance coverage relates to a plan where we are not participating providers, you will will be 100% responsible for these charges. All co-pay and deductibles are due at the time of service. By signing below, I authorize direct payment of medical benefits to the attending physicians or to whomever he/she designates. I understand that I am personally responsible to the physician for all charges for services that are not covered by my insurance.

* **PATIENT SIGNATURE:** _____ **DATE:** _____

MEDICARE PATIENTS ONLY

Statement to Permit Payment of Medicare Benefits to Provider, Physicians and Patient
Payment for services rendered is to be made as follows: "I request that payment of authorized Medicare benefits be made, I authorize any holder of medical information about me to release to the Health Care financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

* **PATIENT SIGNATURE:** _____ **DATE:** _____

NCO History and Review of Systems

Patient Name*:** _____ ***Date of Birth _____

Please answer the following questions about your medical history:

Last Exam Date: _____ **Where:** _____

Have you ever been treated for any of the following conditions Diabetes (Type: 1 or 2) High Blood Pressure Heart disease Heart attack Lung disease Thyroid Arthritis Cancer Glaucoma Macular Degeneration Dry Eye Blepharitis Strabismus Retinal Detachment Cataract Glasses Other: _____

Do you wear contact lenses? yes no Brand:

_____

Have you had any type of surgery? (Including medical and/or eye) Cataract Glaucoma Laser Cosmetic Retina Eye Muscle Refractive Other (please specify what year) :_____

Do any medical or eye diseases run in your family? Diabetes High blood Pressure Heart disease Heart attack Arthritis Blindness Cancer Cataract Glaucoma Macular Degeneration Retinal Detachment Other (Please list who it pertains to in your family " Mother, father, ex.")

Other:_____

Do you have any of the following: (ROS)

Rashes Excessive dryness Hearing loss Sinus Problems Sore throat Chest pain Irregular heart beat Shortness of breath Wheezing Coughing Unexpected weight loss/gain Fatigue Heartburn Abdominal pain Diarrhea Vomiting Muscle aches Joint Pain Swollen Joints Numbness/Weakness Paralysis Depression Anxiety Cancer **None**

Other :_____

Are you currently having any of the following problems: (Chief Complaint)

Blurry Vision Floaters (black spots in your vision) Flashes of Light Burning Irritation Foreign Body Sensation Pain Photophobia (light sensitivity) headaches Decreased Vision Loss of Vision right eye/ left eye/ both Redness Itchiness Other:_____

Are you Allergic to any of the following? Amoxycillin Antihistamines Aspirin Codeine Contrast Dye Erythromycin Hydrocodone Ibuprofen Iodine Latex Morphine Neosporin Penicillin Prednisone Steroids Sulfa Drugs other (Please list the affect this had on you) _____

Do you smoke? If so how many pack(s) a day? _____ Do you drink? If so how much per week? _____

Do you take any *medications*? Yes No….. If yes please list below.

Name of Medicine	Dose	For what Condition	How Often

Do you use any eye drops and/or ointments? Yes/ No….. If yes please list below.

Name of Medicine	Dose	For what Condition	How Often

_____

Doctor Signature Date

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Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for NEW CENTURY OPHTHALMOLOGY GROUP, PLLC to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (NEW CENTURY OPHTHALMOLOGY GROUP, PLLC Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. NEW CENTURY OPHTHALMOLOGY GROUP, PLLC reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to NEW CENTURY OPHTHALMOLOGY GROUP, PLLC Privacy Officer at P.O. BOX 914, 1001 COLLEGE ST. OXFORD, NC 27565

With this consent, NEW CENTURY OPHTHALMOLOGY GROUP, PLLC may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, NEW CENTURY OPHTHALMOLOGY GROUP, PLLC may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, NEW CENTURY OPHTHALMOLOGY GROUP, PLLC may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that New Century Ophthalmology, restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to NEW CENTURY OPHTHALMOLOGY GROUP, PLLC use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, NEW CENTURY OPHTHALMOLOGY GROUP, PLLC may decline to provide treatment to me.

- A copy of NEW CENTURY OPHTHALMOLOGY GROUP, PLLC privacy notice is posted and at my disposal should I want to review it. I may also request a copy of this form to keep for my records at anytime.

_____
Signature of Patient or Legal Guardian

_____ _____
Print Patient's Name Date