Perez Li Ophthalmology
2905 Enterprise Drive
Anderson, IN 46016
Telephone: 765-649-7146
Fax: 765-646-6042

Patient Information

Date: _____ SSN #: _____ Date of Birth: _____

Name: _____,_____, _____
(Last Name) (First Name) (Middle Int'l)

Address: _____

City: _____ State: _____ Zip: _____

Main Phone #: _____ (Circle) Home Cell Work

Secondary Phone #: _____ (Circle) Home Cell Work

Email Address: _____

Sex: Male or Female Marital Status: Minor Single Married Divorced Widowed

Employer: _____ Occupation: _____

Employer Address: _____ Phone: _____

New Regulations Require the Additional Personal Data

Race: (Please Circle) American Indian Asian African American Caucasian Decline to Answer

Ethnicity: (Please Circle) Not Hispanic/Latino Hispanic/Latino Unknown Decline to Answer

Primary Language: (Please Circle) English Spanish Other_____ Decline to Answer

Emergency Contact Information

Name: _____ Relationship: _____

Address: _____ Phone #: _____

Name: _____ Relationship: _____

Address: _____ Phone #: _____

Patient Medical History

Primary Care Physician: _____ Phone: _____

Did a physician refer you to this office: (Please Circle) YES NO

If yes, what is the physician's name? _____

Do you wear glasses or contacts? _____

Past Medical History (Please Circle)

Illness/Condition	YES	NO
Cancer	YES	NO
AIDS/HIV	YES	NO
High Blood Pressure	YES	NO
Coronary Artery Disease (CHF, Heart Attack)	YES	NO
Arrhythmias	YES	NO
Asthma/Emphysema	YES	NO
COPD	YES	NO
Tuberculosis	YES	NO
Renal/Kidney Insufficiency	YES	NO
Hepatitis	YES	NO
Cirrhosis	YES	NO
Ulcers	YES	NO
Ulcerative Colitis/Crohn's Disease	YES	NO
Cataracts	YES	NO
Glaucoma	YES	NO
Age Related Macular Degeneration (ARMD)	YES	NO
Seizures/Epilepsy	YES	NO
Stroke	YES	NO
Migraines	YES	NO
Depression/Anxiety/Other	YES	NO
Diabetes	YES	NO
Thyroid Abnormality	YES	NO
High Cholesterol	YES	NO
Arthritis	YES	NO
Rheumatoid Arthritis	YES	NO
Pneumonia Vaccine	YES	NO
Smoker	YES	NO
Drinker	YES	NO

Please list the reason for your visit today: _____

_____

Are you currently taking any medications: (Please Circle) YES NO

If yes, please list ALL medications and the associated diagnosis: _____

_____

_____

_____

_____

_____

Allergies: (Please Circle) NONE Other _____

Aspirin Penicillin Sulfa Local Anesthetic Codeine Iodine Latex Barbiturates (sleeping pills)

Are you Diabetic: (Please Circle) YES NO

Notice of Privacy Practices for Perez Li Ophthalmology Group

I, _____, give Perez Li Ophthalmology Group permission to:

1. Leave medical information on an answering machine, voicemail, etc. YES NO
2. Leave medical information with the family member(s) listed below YES NO
3. Release medical information to the following individuals below YES NO

(Medical records and documentation will be sent to all referral doctors and specialists)

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

Patient Signature: _____ Date: _____

PLEASE COMPLETE EVERY SECTION THAT IS APPLICABLE TO YOU

MEDICARE

I hereby authorize by my signature that Perez Li Ophthalmology Group submit a claim on my behalf for payment under the Medicare program. I also authorize by my signature that payment of Medicare program benefits be assigned and made payable on my behalf to Perez Li Ophthalmology Group for all services and supplies provided to me by my doctor. I further authorize the release of my medical information to Medicare should Medicare require the information in order to adjudicate the amount due to Perez Li Ophthalmology Group.

Patient Signature: _____ Date: _____

ALL OTHER INSURANCE INCLUDING SOCIAL SECURITY DISABILITY & VA

I hereby authorize by my signature that Perez Li Ophthalmology Group submit a claim on my behalf for payment of benefits available through my coverage with _____.
I also authorize by my signature that all payments through my insurance carrier be assigned and made payable on my behalf to Perez Li Ophthalmology Group for all services and supplies provided to me by my doctor. I further authorize the release of my medical information to Medicare should Medicare require the information in order to adjudicate the amount due to Perez Li Ophthalmology Group.

Patient Signature: _____ Date: _____

TO BE COMPLETED BY ALL PATIENTS

I understand that Perez Li Ophthalmology Group will submit a claim on my behalf to my insurance carrier. I agree to pay upon the receipt of a bill, the full amount due and payable for the services and supplies I have received, less applicable insurance payments, unless prior payment arrangements have been made. I understand that I will be responsible for all costs associated with the collection of my balance due with the collection of my balance due, including collection fees and attorney's fees, should the balance become delinquent. I fully understand that I am financially responsible for the payment of the full amount of services and supplies that I receive and I agree to pay the full amount or balance due thereof should my insurance carrier fail to make any payment or make a payment for less that the total of the charges. Insurance payments in question are a matter to be resolved between the insurance policyholder and his or her insurance carrier within 30 days of receipt of payment. I agree to pay the account balance in full, which is outstanding more than 30 days beyond the date of receipt of the insurance payment.

Additionally, if I cancel an appointment the same day that it is scheduled, I will incur a charge of $25.00. If I do not call and do not show up for my appointment, I will be charged $40.00.

If you require disability forms to be completed a fee of $35 will be charged. All other forms such as FMLA, parking permits, physician-dictated return-to-work statements and any other record other than medical records will be completed for a fee of $10. All fees are payable at the time of request. If forms or records cannot be completed, any fees paid will be returned.

You may call our billing company at 1-888-501-6638 ext. 133 for all of your billing questions.

Patient Signature: _____ Date: _____