Fuquay Ophthalmology & Glaucoma, PC
Kenneth W. Roach, M.D.
605 Attain Street, Suite #101
Fuquay-Varina, NC 27526-1972

Phone: 919-567-3709
Fax: 919-567-3710

Date: _____

Patient Information

Name: _____ Soc. Sec.#: _____
Last Name First Name Middle Initial

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Additional Phone Contact (cell): _____

Emergency Contact Name: _____ Emerg. Contact Phone Number: _____

Email Address: _____ Birthdate: _____ Age: _____

( ) Single ( ) Married ( ) Separated Sex: ( ) Male ( ) Female

Patient Employed By: _____ Occupation: _____

Business Address: _____

Business Phone: _____

Primary Care Doctor: _____ PCP Phone: _____

Primary Care Doctor Address: _____

Preferred Pharmacy: _____ Pharmacy Phone: _____

How did you hear about us?: ❑ Word of mouth/referral from another patient ❑ Newspaper ad ❑ Phone book

❑Referral from physician ❑ Neighborhood Referrals ❑ Internet ❑Insurance ❑ New Neighbor

Past Medical History/Conditions (Please circle "yes" or "no")

Have you ever had or do you have a history of:

1. Significant blood loss requiring a transfusion? YES NO
2. A history of low blood pressure? YES NO
3. An irregular heartbeat? YES NO
4. Angina? YES NO
5. A previous heart attack? YES NO
6. A history of vascular spasm such as Raynaud's? YES NO
7. Asthma/emphysema/breathing difficulties? YES NO
8. Migraine headaches? YES NO
9. An overactive or underactive thyroid gland? YES NO
10. Cancer of any type? YES NO
11. Diabetes? YES NO

If yes, for how long? _____

Do you use insulin? _____

12. High blood pressure? YES NO

If yes, for how long? _____

13. Glaucoma? YES NO

If yes, for how long? _____

List any other significant medical conditions you have:

_____

_____

_____

Allergies (to medications, foods):

	Medication/Food:	Reaction:	Hospitalization for allergy?:
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Medications:

Medication:	Dosage:	Times/ day:	Medication:	Dose:	Times/ day:
1. _____	_____	_____	6. _____	_____	_____
2. _____	_____	_____	7. _____	_____	_____
3. _____	_____	_____	8. _____	_____	_____
4. _____	_____	_____	9. _____	_____	_____
5. _____	_____	_____	10. _____	_____	_____

Eyedrops:

Name of drop:	Used in which eye?			How many times/day?
1. _____	Right	left	both	_____
2. _____	Right	left	both	_____
3. _____	Right	left	both	_____

Past Surgical History:

Non-eye surgeries	Year:	Eye Surgeries:	Which eye?			Year:
1. _____	_____	1. _____	Right	left	both	_____
2. _____	_____	1. _____	Right	left	both	_____
3. _____	_____	1. _____	Right	left	both	_____

Family History:

Please check if you have a family history of:

( ) glaucoma Which relative? _____

( ) retinal problems Which relative? _____

( ) inturned/outturned eye Which relative? _____

( ) diabetes Which relative? _____

( ) macular degeneration Which relative? _____

List any other medical problems which run in your family: _____

Social History:

Do you smoke cigarettes? YES NO

If yes, how many packs/day? _____
For how many years? _____
If no, did you smoke before? _____
When did you quit? _____

Do you drink alcohol? YES NO

If yes, how many drinks a week? _____
If no, did you drink before? _____
When did you quit? _____

Do you use or have you used intravenous drugs in the past? YES NO

Eye History:

Did you ever have a crossed or "lazy" eye as a child? YES NO

Have you ever had a retinal tear or detachment? YES NO

Have you ever had a significant eye injury? YES NO

If yes, what type of injury and when? _____

Do you have light sensitivity? YES NO

Do you see flashes of light or floaters? YES NO

Are they new or old? _____

Do you have blurred vision? YES NO

Do you have halos around lights? YES NO

Contact Lenses:

Do you wear contact lenses? YES NO

If so, what type? _____

How many hours a day do you wear your contact lenses? _____

What type of cleaning/storage solution do you use? _____

Have you ever had a contact lens related eye infection? YES NO

Do you sleep in your contact lenses/wear your contact lenses overnight? YES NO

Review of Systems:

Please check if you have or have had any of the following:

Allergic:	( ) seasonal allergies	( ) food allergies	( ) asthma
Cardiovascular:	( ) recent chest pains	( ) palpitations	( ) heart murmur
Constitutional:	( ) fever	( ) weight loss	( ) fatigue
ENT:	( ) sinus problems	( ) hearing loss	( ) ringing of ears
Endocrine:	( ) cold intolerance	( ) heat intolerance	( ) recent hair loss
Gastrointestinal:	( ) recent bowel habit changes	( ) recent appetite changes	( ) nausea/vomiting
Genitourinary:	( ) burning with urination	( ) recent UTI	( ) kidney stones
Hematologic:	( ) easy bruising	( ) frequent bleeding	( ) anemia
Integumentary:	( ) recent rashes	( ) prior skin cancer	
Musculoskeletal:	( ) recent joint pain	( ) stiffness	( )muscle aches
Neurologic:	( ) recent headaches	( ) dizziness	
Psychiatric:	( ) difficulty sleeping		
Respiratory:	( ) difficulty breathing	( ) recent cough	( ) wheezing

Other: _____

Insurance Information

IF THE INSURANCE POLICYHOLDER IS THE SAME AS THE PATIENT, PLEASE CHECK HERE: ☐

Name of policy holder: _____
Last name First name Middle initial

Relation to patient: _____ Birthdate: _____ Soc. Sec.# _____

Address (if different from patient): _____

City: _____ State: _____ Zip Code: _____

Phone: _____

Person responsible employed by: _____ Occupation: _____

Business Address: _____

City: _____ State: _____ Zip Code: _____

Business Phone: _____

Insurance Company (primary): _____

Contract# _____ Group# _____ Subscriber I.D.# _____

Insurance Company (secondary): _____

Contract# _____ Group# _____ Subscriber I.D.# _____

Assignment of Insurance Benefits

I, the undersigned, have insurance coverage with: _____
Name of insurer

and assign directly to Fuquay Ophthalmology and Glaucoma, P.C. all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. If for any reason the account should become delinquent, I agree to pay for all rebilling charges, collection costs, and reasonable legal fees in addition to the amount owed. I hereby authorize Fuquay Ophthalmology and Glaucoma, P.C. to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____
Signature of Insured/Guardian Date

Medicare Authorization

I request that payment of authorized Medicare benefits be made to Fuquay Ophthalmology and Glaucoma, P.C. for any services furnished me by that practice. 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. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claims forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and deductions are based upon the charge determination of the Medicare carrier. If for any reason the account should become delinquent, I agree to pay for all rebilling charges, collection costs and reasonable legal fees in addition to the amount owed.

_____ _____
Beneficiary Signature Date

Fuquay Ophthalmology & Glaucoma, PC
Kenneth W. Roach, M.D.
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Phone: 919-567-3709

Acknowledgement of Receipt of Office Policy Regarding Refractions and Contact Lenses

I, the undersigned, have received a copy of Fuquay Ophthalmology and Glaucoma, PC's policy regarding refractions and contact lens fittings, and understand that I am financially responsible for these services if they are not covered by my health care insurance.

_____ _____
Signature of Patient/Legal Guardian Date

Acknowledgement of Receipt of Privacy Practices

I, _____, have received a copy of Fuquay Ophthalmology and Glaucoma, PC's
Patient Name

Notice of Privacy Practices.

_____ _____
Signature of Patient/Legal Guardian Date

Authorization for Use and Disclosure of Protected Health Information

By signing this authorization, I authorize Fuquay Ophthalmology and Glaucoma, PC to use and/or disclose

certain protected health information (PHI) about me to _____.
Person/organization allowed to receive information

This authorization permits Fuquay Ophthalmology and Glaucoma, PC to use and/or disclose the following individually identifiable health

information about me: _____
Description of the information allowed to be disclosed (types of services, dates of visits, etc...)

This authorization will expire on: _____.
Expiration Date

The practice will not receive payment or other renumeration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from Fuquay Ophthalmology and Glaucoma, PC. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to:

Fuquay Ophthalmology and Glaucoma, PC
605 Attain Street, Suite #101
Fuquay-Varina, NC 27526-1972

_____ _____
Signature of Patient/Legal Guardian Date

_____ _____
Patient's Name Date