

Patient Last Name	First Name	Middle Name	Maiden Name
Address (Street or Box)		City	State   Zip Code
Home Phone Number	Cell Phone Number	Work Phone Number	E-Mail
Social Security Number	Date of Birth	Assigned Sex at Birth <input type="checkbox"/> Male <input type="checkbox"/> Female	Pronouns <input type="checkbox"/> She/Her/Hers <input type="checkbox"/> He/Him/His <input type="checkbox"/> They/Them/Theirs <input type="checkbox"/> Other: Please specify: _____
Gender Identity (Check One) <input type="checkbox"/> Identify as Male <input type="checkbox"/> Identify as Female <input type="checkbox"/> Gender Nonconforming/Non-binary <input type="checkbox"/> Other (Please specify) _____ <input type="checkbox"/> Choose not to disclose		Sexual Orientation (Check One) <input type="checkbox"/> Lesbian/Gay/Homosexual <input type="checkbox"/> Straight/Heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Something else, please describe _____ <input type="checkbox"/> Don't Know <input type="checkbox"/> Choose not to disclose	
Marital Status (Check One) <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Unknown		Race (Check One) <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Other _____	
Ethnicity (Check One) <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Hispanic or Latino		Employer Name	Employer Address
Is patient residing in a Skilled Nursing Facility/ Rehabilitation Center? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, Name of Facility	City: Phone Number:
Primary Care Physician Name		Phone Number	
Emergency Contact & Relationship	Phone Number	Referring Physician Name	Phone Number

Patient Information

Complete this section ONLY if Patient is a minor or has a Legal Guardian			
Responsible Party Last Name	First Name	Middle Name	E-Mail:
Address (Street or PO Box)		City	State   Zip Code
Home Phone Number	Cell Phone Number	Work Phone Number	
Relationship to Patient <input type="checkbox"/> Self <input type="checkbox"/> Other (specify)	Date of Birth	Social Security Number	

Responsible Party

<b>PRIMARY</b> Insurance Company	Effective Date	<b>SECONDARY</b> Insurance Company	Effective Date
Claims Mailing Address (Street or PO Box)		Claims Mailing Address (Street or PO Box)	
City	State   Zip Code	City	State   Zip Code
Policy ID Number	Group ID Number	Policy ID Number	Group ID Number
Subscriber Name (Policy Holder)	Date of Birth	Subscriber Name (Policy Holder)	Date of Birth
Subscriber Social Security Number	Relationship to Patient	Subscriber Social Security Number	Relationship to Patient
Subscriber Employer	Work Phone Number	Subscriber Employer	Work Phone Number
Subscriber Employer Address (Street or PO Box)		Subscriber Employer Address (Street or PO Box)	
City	State   Zip Code	City	State   Zip Code

Insurance and Subscriber Information

Preferred Pharmacy Name	Pharmacy Address	Pharmacy Phone Number
Mail-Order Pharmacy Name	Pharmacy Address	Pharmacy Phone Number

Pharmacy

### Vision Insurance (if applicable)

Vision Insurance and Subscriber Information

VISION Insurance Company		Effective Date
Claims Mailing Address (Street or PO Box)		
City	State	Zip Code
Policy ID Number	Group ID Number	
Subscriber Name (Policy Holder)	Date of Birth	
Subscriber Social Security Number	Relationship to Patient	
Subscriber Employer	Work Phone Number	
Subscriber Employer Address (Street or PO Box)		
City	State	Zip Code

\_\_\_\_\_  
Signature of Patient, Parent, or Legal Guardian

\_\_\_\_\_  
Date

**Consent to Treat and Financial Responsibility**

Consent to Treat CMEA\_NP\_F101

I hereby authorize employees and agents of The Retina Group of Washington, PLLC ("RGW") dba Central Maryland Eye Associates, an Affiliate of PRISM Vision Group, including physicians, physician assistants, nurse practitioners and other employees and staff members to render medical evaluations and care to the patient indicated below. The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in the case of an emergency.

\_\_\_\_\_  
**Patient Name (Please PRINT)**

\_\_\_\_\_  
**Signature of Patient, Parent, or Legal Guardian**

\_\_\_\_\_  
**Date**

***Complete this section ONLY if patient is a minor or requires a Legal Guardian***

I consent for \_\_\_\_\_ to authorize evaluation and treatment for the patient identified above when I am not available. I understand that this authorizes the foregoing person(s) to consent to medical and surgical procedures and immunizations for the patient. The duration of this consent is indefinite and continues until revoked in writing.

\_\_\_\_\_  
**Signature of Patient, Parent, or Legal Guardian**

\_\_\_\_\_  
**Date**

Financial Responsibility CMEA\_NP\_F102

I hereby authorize The Retina Group of Washington, PLLC ("RGW") dba Central Maryland Eye Associates, an Affiliate of PRISM Vision Group, to apply for benefits on my behalf and for payment of medical benefits directly to RGW for services rendered. I request payments of Medicare, Medigap and/or any other insurance company to be made directly to RGW. Authorization is hereby granted to release information contained in the patients' medical record or the patient's medical insurance company (or its employees or agents) as may be necessary to process and complete the patient's medical claim. I understand that I am financially responsible for all charges for services rendered which may include services not covered by the patient's insurance companies. I agree that all amounts are due upon request and are payable to RGW.

The duration of this authorization is indefinite and continues until revoked in writing. I understand that by not signing this release of information, I am responsible for payment of services in full before services are rendered.

\_\_\_\_\_  
**Patient Name (Please PRINT)**

\_\_\_\_\_  
**Signature of Patient, Parent, or Legal Guardian**

\_\_\_\_\_  
**Date**

Preferred Method of Communication CMEA\_NP\_F104

**Yes**, I want The Retina Group of Washington, PLLC ("RGW") dba Central Maryland Eye Associates, an Affiliate of PRISM Vision Group, to communicate my information with me through a secure system that is designed to keep my information safe.

My preferred method of communication regarding my medical conditions and/or appointment information is indicated below:

Home Phone       Cell Phone       Email       Mailed Letter       Guardian

If the above method of communication is by **phone**, please do one of the following (**please check ONE**):

- Leave a message with detailed information.
- Leave a message with a call-back number only.

If the above method of communication is by **email**, please consider the privacy implications; for example, any other person that may have access to your e-mail address or any other person, such as your employer, that may have the right and/or ability to review all e-mail received at your work address.

**Please let our office know if you have any special directions or requests regarding our communication with you. For example, please let us know if you would like us to call you at a different phone number for a specific test result or if you do not want to be contacted at all.**

Approved HIPAA Contacts CMEA\_NP\_F105

Keeping our patient's information private is important to us, and by default we will disclose information related to the patient's Billing Account and Medical Conditions only to the patient or legal guardian.

If you would like to add additional contacts, other than the patient or legal guardian, that The Retina Group of Washington, PLLC ("RGW") dba Central Maryland Eye Associates, an Affiliate of PRISM Vision Group, is allowed to disclose this type of information to, please complete the fields below and select the appropriate checkboxes based on your approval for each person you listed. If the End Date is left blank, then the duration of this authorization is indefinite unless otherwise revoked in writing.

Contact Name	Relationship to Patient	Contact Phone Number	End Date
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**Billing Account Information**       **Medical Condition Information**       **Emergency Contact**

**Additional Notes:** \_\_\_\_\_

Contact Name	Relationship to Patient	Contact Phone Number	End Date
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**Billing Account Information**       **Medical Condition Information**       **Emergency Contact**

**Additional Notes:** \_\_\_\_\_

**Notice of Privacy Practices and Acknowledgement of Receipt**

CMEA\_NP\_F107

Notice of Privacy Practices and Acknowledgement of Receipt

**Patient Name:** \_\_\_\_\_

**Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

*The Notice of Privacy Practices describes how Protected Health Information about you may be used and disclosed and how you can get access to this information. Please review carefully.*

The Retina Group of Washington, PLLC (“RGW”) dba Central Maryland Eye Associates, an Affiliate of PRISM Vision Group, is required by law to protect the privacy of health information that may reveal your identity, and to provide you with a copy of this notice, which describes the health information privacy practices of our practice, its medical staff, and affiliated health care providers that jointly perform payment activities and business operations with our Practice. “Protected Health Information” is information about you, including demographic information, that may identify you as well as genetic information, and information that relates to your past, present or future physical or mental health or condition and related health care services.

On \_\_\_\_/\_\_\_\_/\_\_\_\_, I, \_\_\_\_\_, received a copy of this office’s Notice of Privacy Practices.  
(Today’s Date) (Patient’s Name)

\_\_\_\_\_  
**Please Print Name**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

\*Central Maryland Eye Associates’ Notice of Privacy Practices can also be found on our website: <https://centralmarylandeye.com>

**For Office Use Only**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

***This Acknowledgement Form will become part of your permanent medical record.***

**Medical Questionnaire / Eye History**  
CMEA NP F108

Patient's Name:		Date / /	
What ocular problem brings you in?			
When was your last eye exam?	/ /	Eye Doctor	
What did your doctor tell you?			
YES NO			
Do you wear glasses for vision?			
Do you wear contact lenses?		If so, last time they were changed?	
Do you have Glaucoma?		If so, how is it being treated?	
Have you had cataract surgery?		If so, Which Eye?	Date of Surgery Name of Surgeon
		Left Eye	/ /
		Right Eye	/ /
Have you had other surgery? Please list details below			

**Medical History – Social History**

Have you ever suffered from any of the following?

	YES	NO	Comment
Born Prematurely?			
History of Weight Loss, Fever?			
Headaches, Sinus, Tonsillectomy?			
Heart Condition?			
High Blood Pressure?			
Circulatory Problems?			
Lung Disease?			
Ulcers, Liver, Gall Bladder Disease?			
Do you Smoke?			
Do you Drink?			
Kidney, Bladder, Prostate Disease?			

	YES	NO	Comment
Joint Disease?			
Skin Disease or Breast Cancer?			
Stroke or Neurological Disease?			
History of Psychological Disease?			
Thyroid Disease?			
Diabetes?			
Date of Last Blood Sugar Results:			
Bleeding Disorder, Anemia?			
Aids or Infectious Disease?			
Cancer?			

List ALL Medications that you are presently taking, including any eye drops:

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List ALL Allergies Including Medications:

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**FAMILY HISTORY**

Is there a family history of	YES	NO	Relative:
Cataracts?			
Glaucoma?			
Retinal Disease?			
Diabetes?			
Hypertension?			
Anemia?			
Other Eye or Systemic Disease?			

## Medical History Questionnaire / Review of Symptoms

CMEA NP F109

Patient's Name:	Date        /        /
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Do you have any problems in the following areas? *Please check all applicable*

YES        NO

YES        NO

<b>GENERAL</b>				
Fever				
Fatigue				
Weight Loss / Gain				
Frequent Colds				
<b>EYES</b>				
Blurred Vision				
Double Vision				
Redness				
Sandy or Gritty Feeling				
Blind Spots				
Floaters				
Flashes				
Lazy Eye				
Itching / Burning				
Excess Tearing				
Glare / Light Sensitivity				
Eye Pain				
Chronic Infection Eye / Lid				
<b>ENT: Ears, Nose &amp; Throat</b>				
Sinus Infection				
Cough				
Trouble Walking				
Hoarseness				
Loss of Hearing				
Nose Bleeds				
<b>HEART</b>				
Chest Pain				
Irregular Heart Beat				
Pacemaker				
Heart Murmur				
Swollen Feet / Ankles				
Leg Cramps when Walking				
<b>LUNGS</b>				
Wheezing, Shortness of Breath				
Coughing up Blood / Phlegm				
<b>GI / GU</b>				
Vomiting				
Bloody Bowel Movement				
Heartburn				
Loss of Appetite				
Difficulty with Urination				
Blood in Urine				
Frequent Urination				
Pain in Urination				
<b>MUSCULOSKELETAL</b>				
Muscle Pain				
Joint Pain, Arthritis				
<b>INTEGUMENTARY</b>				
Rash, Bruise Easily				
Breast Disease				
<b>NEUROLOGICAL</b>				
Fainting, Frequent Headaches				
Seizures				
<b>PSYCHIATRIC</b>				
Depression				
Anxiety				
Psychiatric Problems				
<b>ENDOCRINE</b>				
Excessive Thirst				
Excessive Sweating				
<b>HEMATOLOGIC / LYMPHATIC</b>				
Swollen Glands				
<b>ALLERGIC / IMMUNOLOGIC</b>				
Seasonal Allergies				
Hay Fever				
<b>OTHER</b>				
Pregnant				
Menopausal				
Vaginal Bleeding				
Breast Lumps				
<b>COMMENTS REGARDING ABOVE ANSWERS: (PLEASE PRINT)</b>				