Hogan Eye Associates, Inc.
133 Loudon Rd., Suite 5, Concord, NH 03301
Phone: 603-224-3351 Fax: 603-225-7575

Donna M. Hogan, O.D.
Timothy J. Hogan, O.D.
www.hoganeye.com

PATIENT INTAKE FORM

PATIENT INFORMATION

PATIENT LEGAL NAME:	DOB:	DATE:		
PREFERRED NAME:	GENDER:	AGE:		
ADDRESS 1:	PHONE 1:	☐ HOME	☐ MOBILE	☐ OTHER
ADDRESS 2:	PHONE 2:	☐ HOME	☐ MOBILE	☐ OTHER
CITY, STATE, ZIP:	EMAIL:			
EMPLOYER:	*YOU WILL RECEIVE PERIODIC MESSAGES RELATED TO YOUR APPOINTMENTS, ORDERS, AND PROMOTIONAL MESSAGES BY TEXT AND EMAIL. IF YOU DO NOT WISH TO RECEIVE IMPORTANT MESSAGES BY TEXT OR EMAIL, THE ABILITY TO OPT-OUT IS PROVIDED WITHIN EACH TEXT AND EMAIL.			
OCCUPATION:				
SSN (IF INS. REQUIRES):				

RESPONSIBLE PARTY (IF PATIENT IS A MINOR)

FULL NAME:	DOB:	PHONE:
ADDRESS:	EMAIL:	
CITY, STATE, ZIP:	RELATIONSHIP TO PATIENT:	

VISION INSURANCE	POLICYHOLDER INFORMATION (IF NOT PATIENT)	
INSURANCE COMPANY:	NAME:	PHONE:
POLICY NUMBER:	ADDRESS:	
GROUP NUMBER:	CITY, STATE, ZIP:	DOB:

PRIMARY MEDICAL INSURANCE	POLICYHOLDER INFORMATION (IF NOT PATIENT)	
INSURANCE COMPANY:	NAME:	PHONE:
POLICY NUMBER:	ADDRESS:	
GROUP NUMBER:	CITY, STATE, ZIP:	DOB:

SECONDARY MEDICAL INSURANCE	POLICYHOLDER INFORMATION (IF NOT PATIENT)	
INSURANCE COMPANY:	NAME:	PHONE:
POLICY NUMBER:	ADDRESS:	
GROUP NUMBER:	CITY, STATE, ZIP:	DOB:

PRIMARY CARE PROVIDER (PCP) INFORMATION

PHYSICIAN NAME:	PHONE:

☐ BY CHECKING THIS BOX I AGREE TO HAVE MY RECORDS AND/OR DIAGNOSIS INFORMATION SHARED WITH MY PHYSICIAN

PHARMACY INFORAMTION

PHARMACY NAME:	ADDRESS:

HOW DID YOU HEAR ABOUT US

☐ FRIEND - NAME:	☐ OTHER PROVIDER - NAME:	☐ ONLINE - SEARCH ENGINE NAME:

AUTHORIZATION TO TREAT & STATEMENT OF FINANCIAL RESPONSIBILITY

I hereby authorize: **the doctors and staff of Hogan Eye Associates, Inc. to provide treatment to me or the above-named patient. I agree to the diagnostic tests, procedures, and the administration of pharmaceutical agents and medications that are best for my overall health. I acknowledge that no guarantees or assurances have been made to me concerning the results or findings intended from treatment or examination.**

I understand **that most insurance policies pay only a portion of my total charges. If I have questions about my coverage, I will contact my insurance company. The doctors and staff of Hogan Eye Associates, Inc. do not guarantee the accuracy of the benefit information provided to them by my insurance company. It is my responsibility to provide all insurance information prior to the appointment so my benefits may be verified, and today's exam and/or materials will be billed to my insurance company. Once billed to the insurance company, it cannot be changed or cancelled. I am responsible for any copays, coinsurance, deductibles, and balances that my insurance company does not pay, and all co-payments and balances are due at the time of check-in. Any returned checks will result in a $25.00 fee. Hogan Eye Associates, Inc. will only bill insurances that they are contracted with. I am responsible for knowing who my insurance(s) is, and what my insurance(s) covers. I am responsible for knowing whether a referral from my primary care physician (PCP) is needed and for obtaining that referral. A 48-hour notice is required to cancel an appointment. Patients may be billed for appointments that are cancelled/missed with less than a 48-hour notice.**

Medicare & Commercial Insurance: **I request that payment of authorized Medicare or Commercial Insurance benefits be made on my behalf to Hogan Eye Associates, Inc. for any services furnished to me by that physician. I authorize the release of any medical information about me to the Health Care Financing Administration and its agents, as well as any information needed to determine these benefits payable for related services.**
I hereby authorize Medicare to furnish to the above-named Doctor or Group any information regarding my Medicare claims under title XVIII of the Social Security Act. I hereby authorize the release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to the Doctor or Group indicated on the claim.

Hogan Eye Associates, Inc. does not release my personal information unless authorized by the Patient, Parent/Guardian, or Authorized Representative. I acknowledge that I have received a copy of the Hogan Eye Associates, Inc. HIPAA privacy statement. Please ask for a copy if you would like one.

☐ **I have read and understood all of the above.** **(A copy of the signature is as valid as the original.)**

SIGNATURE: _____ **DATE:** _____

(To be signed by the patient, parent/guardian, or authorized representative)

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MEDICAL HISTORY QUESTIONAIRE

NAME:	DOB:	OCCUPATION:		
PCP:	LAST PHYSICAL EXAM:	LAST EYE EXAM:		
DO YOU CURRENTLY WEAR:	□ GLASSES	□ CONTACTS	□ BOTH	□ NONE
IF WEARING CONTACTS:	PRODUCT NAME:	SPHERE:	BASE CURVE:	DIAMETER:
WITH YOUR CURRENT PRESCRIPTION, ARE YOU EXPERIENCING BLURRY VISION?	□ DISTANCE	□ NEAR	□ BOTH	□ NONE
IF NO CURRENT PRESCRIPTION, ARE YOU EXPERIENCING BLURRY VISION?	□ DISTANCE	□ NEAR	□ BOTH	□ NONE

ARE YOU EXPERIENCING ANY OF THE FOLLOWING SYMPTOMS TODAY?

RED EYE	□ YES □ NO	**EYE PAIN**	□ YES □ NO
FLOATERS	□ YES □ NO	**SPOTS IN VISION**	□ YES □ NO
FLASHING LIGHTS	□ YES □ NO	**DRYNESS**	□ YES □ NO
ITCHINESS	□ YES □ NO	**WATERY**	□ YES □ NO
SWOLLEN LIDS	□ YES □ NO	**DISCHARGE**	□ YES □ NO

HEADACHES □ YES □ NO	**IF YES:** LOCATION:	SEVERITY:	FREQUENCY:	TIMELINE:

HAVE YOU BEEN DIAGNOSED WITH ANY OF THE FOLLOWING?

□ CATARACTS	□ GLAUCOMA	□ LAZY EYE	□ MACULAR DEGENERATION
□ RETINAL DETACHMENT	□ RETINAL HOLE	□ RETINAL TEAR	
□ LIST ANY OTHER OCULAR CONDITIONS:			

HAS ANYONE IN YOUR FAMILY BEEN DIAGNOSED WITH THE FOLLOWING?

□ CATARACTS	WHO:
□ GLAUCOMA	WHO:
□ MACULAR DEGENERATION	WHO:
□ LIST ANY OTHER OCULAR CONDITIONS AND WHO:	

HAVE YOU BEEN DIAGNOSED WITH ANY OF THE FOLLOWING?

□ HYPERTENSION	MEDICATION:
□ CHOLESTEROL	MEDICATION:
□ HEART DISEASE	MEDICATION:
□ THYROID	MEDICATION:
□ ARTHRITIS	MEDICATION:
□ DEPRESSION/ANXIETY	MEDICATION:
□ CANCER	MEDICATION:
□ EPILEPSY/SEIZURE DISORDER	MEDICATION:
□ ASTHMA/COPD	MEDICATION:
□ DIABETES/SUSPECT	MEDICATION:

IF DIABETIC/SUSPECT, WHEN WERE YOU DIAGNOSED:	LAST BLOOD SUGAR:	LAST A1C & WHEN:
□ LIST ANY OTHER MEDICAL CONDITIONS:		
□ LIST ANY OTHER MEDICATIONS:		

HAS ANYONE IN YOUR FAMILY BEEN DIAGNOSED WITH THE FOLLOWING?

□ DIABETES	WHO:		
□ HYPERTENSION	WHO:		
□ CANCER	WHO:		
□ CARDIOVASCULAR DISORDER	WHO:		
□ ANY OTHER MEDICAL CONDITIONS	WHO:		
HAVE YOU HAD ANY EYE SURGERIES:	□ YES □ NO	WHAT TYPE & WHEN:	
HAVE YOU HAD ANY OTHER SURGERIES:	□ YES □ NO	WHAT TYPE & WHEN:	
ARE YOU PREGNANT OR NURSING:	□ YES □ NO	HOW MANY WEEKS:	
DO YOU SMOKE:	□ YES □ NO	PACKS PER DAY:	YEARS SMOKING:
DO YOU DRINK:	□ YES □ NO	HOW OFTEN:	
LIST ANY ALLERGIES:			

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AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

NAME:				**DOB:**		
ADDRESS:		**PHONE 1:**		□ **HOME**	□ **MOBILE**	□ **OTHER**
CITY, STATE, ZIP:		**PHONE 2:**		□ **HOME**	□ **MOBILE**	□ **OTHER**

I authorize the release of protected health information identifying me (including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services) under the following terms and conditions:

FROM:	**PREVIOUS EYE DOCTOR**	**TO:**	
NAME:		**NAME:**	**HOGAN EYE ASSOCIATES, INC.**
ADDRESS:		**ADDRESS:**	**133 LOUDON ROAD, SUITE 5**
CITY, STATE, ZIP:		**CITY, STATE, ZIP:**	**CONCORD, NH 03301**
PHONE:		**PHONE:**	**603-224-3351**
FAX:		**FAX:**	**603-225-7575**

1. Detailed description of the information to be released:

2. The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual):

3. Expiration date _____ or the event relating to the individual or purpose for the release:

It is completely your decision whether to sign this authorization form or not. We cannot refuse to treat you if you choose not to sign this authorization. If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send the note to the office contact information listed at the top of this form. When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state, or federal law changes this possibility. (For marketing authorizations, include, as applicable: We will receive direct or indirect remuneration from a third party for disclosing your protected health information in accordance with this authorization.)

□ I have read and understood this form. I am signing it voluntarily. I authorize the disclosure of my protected health information as described in this form.

SIGNATURE:		**DATE:**	

(PATIENT, PARENT/GUARDIAN, OR AUTHORIZED REPRESENTATIVE)

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EMERGENCY CONTACT & RELEASE OF INFORMATION AUTHORIZATION

NAME:		**DOB:**	
ADDRESS:		**PHONE:**	
CITY, STATE, ZIP:		**EMAIL:**	

LISTED BELOW IS MY EMERGENCY CONTACT INFORMATION:

EMERGENCY CONTACT 1:		**RELATIONSHIP:**	
ADDRESS:		**PHONE:**	
EMERGENCY CONTACT 2:		**RELATIONSHIP:**	
ADDRESS:		**PHONE:**	
EMERGENCY CONTACT 3:		**RELATIONSHIP:**	
ADDRESS:		**PHONE:**	

I AUTHORIZE THE REALEASE OF THE SELECTED PROTECTED HEALTH INFORMATION TO THE ABOVE NAME INDIVIDUAL(S) INCLUDING: (PLEASE CHECK ALL THAT APPLY)

☐ **DIAGNOSIS**	☐ **TREATMENT PLANS**	☐ **APPOINTMENTS**
☐ **BILLING**	☐ **CLAIMS**	☐ **ALL RECORDS**

☐ **DO NOT RELEASE MY PROTECTED HEALTH INFORMATION. ONLY CONTACT THE ABOVE-NAMED INDIVIDUAL(S) IF I HAVE AN ACCIDENT OR A MEDICAL EPISODE WHILE IN YOUR OFFICE.**

I UNDERSTAND THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL TERMINATED BY ME IN WRITING. I HAVE READ AND UNDERSTOOD THE ABOVE INFORMATION AND DO HEREBY AUTHORIZE THE RELEASE OF MY SELECTED PROTECTED HEALTH INFORMATION TO THE INDIVIDUAL(S) NAMED ABOVE.

SIGNATURE:		**DATE:**	

(PATIENT, PARENT/GUARDIAN, OR AUTHORIZED REPRESENTATIVE)