Patient Information Sheet Chart # _____ Date _____

Name First MI Last Birthdate Age

Address Bldg.# Apt. # City State ZIP

Social Security # Home Phone Bus. Phone # Cell Phone # Sex Marital Status

Employer Address Phone #

Nearest Relative (*other than spouse*) Address Cell No. / Home / Bus #

Responsible Party for Payment Address Phone #

Subscriber to Insurance (***if not patient***) Social Security. # Birthdate Phone #

Subscriber's Employer (If Other Than Patient) Subscriber Birthdate

Insurance (Primary) Group # Policy # Subscriber

Insurance (Secondary) Group # Policy # Subscriber

Referred By Allergies

Family Physician (PCP) ***mandatory*** Address *or* Phone #

Current Medications/Recent Illnesses or Operations

Family Members Who Are Patients

Signature _____ Date _____

MERCER EYE ASSOCIATES

INITIAL VISIT INSTRUCTIONS

1. **Effective 8/1/09, HIPPA Privacy Law requires us to copy a photo ID on all patients. Please bring appropriate ID to be copied and made part of your patient file.**

2. **A new patient visit may take approximately 1 or 1 ½ hours., as you will be dilated during the course of your examination. You may want to bring a driver if you have difficulty with dilation. Bright light can be uncomfortable for a period of time following dilation.**

3. **Please bring information regarding your medical and surgical history.**

4. **Please bring a list of all current medications you are taking, including eye drops.**

5. **Please bring your glasses-both distance and reading. We recommend bringing sunglasses for your comfort after dilation. If you are a contact lens wearer please provide your current contact lens prescription. Please contact the office in advance of your appointment to get specific directions for removal of contact lenses before your appointment.**

6. **If you are diabetic, please bring a snack.**

7. **If you do not speak English, a translator is required to come with you.**

8. **Please bring any correspondence from your referring doctor as well as the name and address of any doctors you may want correspondence sent to.**

9. **If you need assistance getting in and out of a chair or using the restroom, you are required to bring someone to assist you.**

MERCER EYE ASSOCIATES, PA

STEVEN ELLIS, M.D. F.A.A.O.
ROBERT CHIANG, M.D. F.A.A.O.
Diplomates, American Board of Ophthalmology
Diseases and Surgery of the Eye

ELAD FELDMAN, M.D. F.A.A.O.
Corneal and External Disease Specialist

Welcome and thank you for choosing Mercer Eye Associates for your eyecare needs. Drs. Ellis, Chiang and Feldman, along with our staff, will provide the highest quality care for you and your family. When you visit our office, your eye health and vision are our top priorities. Our entire team is dedicated to providing you with the personalized care you deserve using only the latest, most innovative techniques in eye care. The doctors perform the most advanced ophthalmic surgery available today, including cataract surgery with multifocal implants and refractive surgery including LASIK.

Attached please find the patient information forms to be completed and **brought in** at the time of your appointment. If it has been more than three years since your last visit , this completed form will expedite your check in.

INSURANCE INFORMATION

As a courtesy to our patients, we try to participate in insurance programs that are a benefit to you and our office. We are participating providers with Medicare. We accept what Medicare **APPROVES.** Medicare pays 80% of the approved amount, and the patient or secondary insurance pays the 20% copayment. There is a $35.00 refraction fee which is not covered by Medicare and most insurances.

We accept most other major insurance companies, please check with our office or consult your insurance carrier for participation status.

It is the **PATIENT'S RESPONSIBILITY** to know your need for referrals and copayments. If a referral is required, please bring it with you at the time of your appointment. Please refer to your benefits department or the member services number on your card for referral requirements. Without proper referrals your appointment may have to be rescheduled.

All payments for copays, refraction fees, or patient charges are expected at the time of service. We accept cash, checks, Visa, MC, Discover, American Express and debit cards.

Your appointment is_____with Doctor_____.

If you cannot keep your scheduled appointment, please notify the office 48 hours in advance so that others may use the appointment time. A $50 missed appointment fee is charged if not cancelled 24 hours in advance.

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