SARATOGA OPHTHALMOLOGY

Amjad M. Hammad, MD, MBA
Salman J. Yousuf, DO
The Center for Vitreo-Retinal Surgery
Charles H. Rheeman, MD
Gregory B. Krohel, MD
The Center for Oculoplastics & Neuro-Ophthalmology
Kamran I. Chaudhri, MD
The Center for Glaucoma & Cataract Surgery

Welcome to Saratoga Ophthalmology!

Thank you for choosing us to provide your medical eye care. We are proud to be one of the regions most experienced ophthalmology practices, and we look forward to serving you.

The forms enclosed will assist us in providing you with the best in eye care. Please complete the forms and bring them with you to your appointment. Also, please know that we require all patients to bring their insurance cards, photo identification, and copayment to their first visit, or we will have to reschedule your appointment.

On the day of your first appointment, we strongly recommend that you have a driver, because both of your eyes will be dilated. Your first appointment will last about 60 to 90 minutes. If you wish to have the doctor discuss your treatment with a relative or friend, please invite that person to join you at your first appointment.

If you have been referred by another doctor, please be sure they have provided you with, or they have forwarded a letter or your medical record to us.

Our office participates with most insurance carriers. If your insurance requires an in-plan referral, please contact your primary care doctor to submit a referral to us via fax:
(518) 580-0557.

If you have any questions whatsoever, please call our office so we may help you:
(518) 580-0553.

Thank you – we look forward to seeing you soon!

Dr. Hammad, Dr. Rheeman, Dr. Krohel, Dr. Chaudhri, Dr. Yousuf, and Staff

658 Malta Avenue, Suite 101
Malta, NY 12020
Phone: 518.580.0553
Fax: 518.580.0557

2200 Burdett Avenue, Suite 206
Troy, NY 12180
Phone: 518.580.0553
Fax: 518.271.6394

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DEMOGRAPHIC INFORMATION

Name: _____ **DOB:** _____/_____/_____

Street Address: _____

City/State/Zip: _____

Marital Status: _____ **SSN**: _____-_____-_____ **Occupation:** _____

Primary Phone: (_____)_____-_____ **Secondary Phone:** (_____)_____-_____

Email Address: _____@_____

Emergency Contact: _____ **Phone:** (_____)_____-_____

Emergency Contact Relationship: _____

The Doctor Who Referred You Here: _____

Your Primary Care Doctor: _____

Your Pharmacy: _____

Your Pharmacy's Phone Number: (_____)_____-_____

If the patient is a minor, please complete guarantor information below:

Name of Guarantor: _____

DOB of Guarantor: _____/_____/_____ **SSN:** _____-_____-_____

Primary Phone: (_____)_____-_____

MEDICAL HISTORY QUESTIONAIRE

Name: _____ DOB: _____/_____/_____

Referring Provider: _____ Primary Care Provider: _____

Pharmacy: _____ Pharmacy Phone: (_____)_____-_____

Drug Allergies: ☐ None known

_____

_____

Prescribed and over the counter medications and supplements: ☐ None

Name	**Dosage**	**Frequency**

Name: _____

Please check all that apply. For <u>YOURSELF,</u> please note current and/or past history of:

☐ **None**

- ☐ **Hypertension _____**
- ☐ **Cardiovascular_____**
- ☐ **Arthritis ☐osteoarthritis (OA), ☐ rheumatoid arthritis (RA)**
- ☐ **Lung _____**
- ☐ **Stroke _____**
- ☐ **Thyroid _____**
- ☐ **Diabetes ☐ Type 1 ☐ Type 2 Last A1c_____**
- ☐ **Cholesterol _____**
- ☐ **Ulcers _____**
- ☐ **Cancer _____**
- ☐ **MS _____**
- ☐ **Graves _____**
- ☐ **Myasthenia Gravis _____**
- ☐ **Other _____**

Family Medical History *<u>Please specify who</u>*, Mother/Father/Grandparent/Sibling/ Etc.:

Please check all that apply. For <u>MEMBERS OF YOUR FAMILY,</u> please note current and/or past history of:☐ None

- ☐ **Hypertension _____**
- ☐ **Cardiovascular_____**
- ☐ **Arthritis _____**
- ☐ **Lung _____**
- ☐ **Stroke _____**
- ☐ **Thyroid _____**
- ☐ **Diabetes ☐ Type 1 ☐ Type 2 _____**
- ☐ **Cholesterol _____**
- ☐ **Ulcers _____**
- ☐ **Cancer _____**
- ☐ **Cataracts_____**
- ☐ **Dry Eyes_____**
- ☐ **Glaucoma_____**
- ☐ **Other _____**
- ☐ **Keratoconus _____**
- ☐ **Macular Degeneration _____**
- ☐ **Retinal Detachment _____**

Do you smoke?: ☐ Yes ☐ No ☐ Former

Name: _____

Surgical History including eye surgeries: ☐ None

Surgery/Procedure	Approx. Date	Provider

Have you had a flu/pneumonia shot? ☐Yes Date: _____ ☐ No

Ocular History:

Current Eye Doctor: _____

Date of last complete eye exam: _____

Do you wear ☐glasses ☐ Contact Lenses? ☐ For Reading ☐ For distance?

Have you ever been diagnosed with?

- ☐ **Cataracts _____**
- ☐ **Glaucoma _____**
- ☐ **Retinal Problems _____**
- ☐ **Cross/Lazy Eye _____**
- ☐ **Eye Injury _____**
- ☐ **Other eye related disease/issue _____**

Please tell us what brings you here today:

_____

_____

Office Use Only

Entered By: _____

Date: _____

Name: _____ DOB: _____/_____/_____

Date: _____

HIPAA POLICY

(Privacy Policy)

Medical Release of Information: I hereby authorize Saratoga Ophthalmology and its representatives to furnish medical information, including photographic or faxed copies of my records to my referring physician(s) and to my insurance company, if requested. As a patient or legal guardian of a patient, I understand that payment for today's service and any future service is ultimately my responsibility. I also authorize a representative of Saratoga Ophthalmology to speak with my insurance carrier on my behalf if required. **I understand that this office bills insurance as a courtesy and that payment of the charges for these services is my responsibility.** A photographic copy of this authorization shall be as valid as the original.

I am aware that I have the opportunity to review the Notice of Privacy Practices before signing this consent (available at the front desk).I hereby authorize Saratoga Ophthalmology to disclose the information about myself (or another person for whom I have authority to sign) that is protected under federal law for the purpose of treatment, payment, and healthcare operations.

I also authorize Saratoga Ophthalmology to communicate with the following individual(s) about my condition or treatment. In accordance with federal laws, I understand that medical information may be withheld from individuals (including family members) unless I list them below.

Name	**Relationship to Patient**
_____	_____
_____	_____
_____	_____

Signature of Patient, Parent, or Legal Guardian: _____

Cancellation Policy

Due to an extremely full appointment book any patient that no shows or fails to give 24 hour notice of a cancellation (up to three times) may be discharged from the practice for non-compliance. Failure to show for an appointment or cancel within 24hours of appointment will result in a $35 fee. We understand delays happen however we must try to keep appointments running on time. If a patient is 15 minutes late we will have to reschedule the appointment.

Signature of Patient, Parent, or Legal Guardian: _____

Refraction Policy

Refraction is the process of determining the eye's refractive error, or need for corrective lenses. However it is considered a non-covered service by Medicare and most insurance companies; thus it becomes the responsibility of the patient to pay for the refraction charger. Our fee for the refraction is $35.00 and is collected at the time of visit, in addition to any copayment, deductible, or balance due on the account. I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service.

Signature of Patient, Parent, or Legal Guardian: _____