Triad Ophthalmic Physicians

Dear Patient,

Welcome to Triad Ophthalmic Physicians, PLLC . Your visit with us will last approximately 2 hours. Your time is very valuable to us, and we understand that our visits are long. We make every effort to complete as many tests or procedures that you may require for your condition so that we may reduce the need for additional visits.

Your appointment takes place at 150 Kimel Park Drive Suite 200 Winston Salem, NC 27103

Your eyes will be fully dilated to ensure a thorough exam.

Please bring the following to each visit:

- Your Drivers' License or Photo ID
- Your current health insurance cards
- Your prescription glasses
- A current list of your medications
- Sunglasses to wear after your appointment
- Your copay is required at the time of visit

Please review and fill out the attached forms, and please do not hesitate to ask any questions. We also need to know who your primary physician is, or any other doctors that may need reports.

We have a 24-hour cancellation policy. If you are unable to make your appointment please contact us at 336-760-2240.

We strive to make your visit to our office as enjoyable as possible. Please let us know if there is anything we can do to make your visit more pleasant.

Thank you so much!

The Doctors and Staff of Triad Ophthalmic Physicians, PLLC

Chanda A. Griessel, M.D.

Triad Ophthalmic Physicians

PATIENT REGISTRATION

Chanda A Griessel, MD

NAME: _____

BIRTHDATE: _____ SEX: M/F RACE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP _____

HOME PHONE: _____ CELLPHONE: _____

EMPLOYER: _____ PHONE _____

SSN: _____ E-MAIL: _____

Primary Insurance: _____ Policy #: _____

Secondary Insurance _____ Policy #: _____

If insurance is through spouse/parent please provide the following information:

NAME: _____ DOB: _____

EMERGENCY CONTACT: _____
RELATION: _____ PHONE: _____

REFERRING PHYSICIAN: _____
PHONE: _____ SEND CORRESPONDENCE: YES/NO

PRIMARY CARE PHYSICIAN: _____
PHONE: _____ SEND CORRESPONDENCE: YES/NO

I certify that I (or my dependent) have insurance coverage as stated above and agree to have insurance payments made directly to Triad Ophthalmic Physicians, PLLC to be applied to my account for services rendered. I understand that I am financially responsible for all charges incurred in the event that my insurance denies payment. I understand and agree that Triad Ophthalmic Physicians, PLLC may release information if necessary for my treatment to process insurance claims. I am aware there may be additional collection and/or attorney's fees if my account is referred for collection.

Patient/Guardian Signature: _____ Date: _____

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Due to the **HIPAA Compliance Privacy Laws of the Federal Government,** it is mandatory that we ask you to review and answer the following questions listed below.

Name: _____

May we leave messages/detailed medical information on voicemail at either of these phone numbers?

□ Yes □ No Home Phone: _____ □ Yes □ No Cell Phone: _____

May we contact you at your place of employment? □ Yes □ No

If so, may we leave a message? □ Yes □ No

If yes: Work Phone: _____ Extension: _____

Do you have any particular person or family members that you authorize to receive and discuss information regarding your personal health information (general information, surgical and billing)?

□ Yes □ No If yes, please provide:

Name: _____ Relationship: _____

Phone Number: _____ Alternate Number: _____

Is this person your Power of Attorney for medical purposes? □ Yes □ No

Name: _____ Relationship: _____

Phone Number: _____ Alternate Number: _____

I hereby authorize _____ _____, to obtain or release any and all pertinent information regarding my medical care, as needed, to assist in my ongoing treatment to or from other health care providers, laboratories, radiology facilities or other institutions. **This authorization remains in effect until revoked.**

I have reviewed the aforementioned information and provide my consent regarding any and all the issues as stated above.

I have reviewed Notice of HIPAA Privacy Policy. A copy of this policy will be provided to me upon request.

Patient Signature: _____ **Date:** _____

WITNESSED BY: _____

150 Kimel Park Drive • Suite 200 • Winston-Salem, NC 27103 • Phone: 336-760-2240 • Fax: 336-760-2239

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Attention

It is the responsibility of the patient to know your insurance and understand your coverage. If your insurance requires a referral from your primary care provider and you do not get a referral, then you are responsible for the charges for that office visit. Also, insurance rarely pays for 100% of your healthcare needs and at times there may be remaining balances on your account due to deductibles, co-pays, or non-covered services. These are also the responsibility of the patient.

All telephone numbers provided by you may be subject to receiving telephone calls from an automated dialer using a pre-recorded, artificial voice message or live operator call. You give your express consent to receive such phone calls, including any calls made to your provided cellular telephone number.

I understand and agree to the above statements:

Patient Signature: _____ Date: _____

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MEDICAL HISTORY

Date_____

Name_____ Date of **last eye exam**_____

What **medications** and **supplements** (Rx & OTC) do you currently take?

_____

Do you have any **allergies** to medications? _____YES _____NO
If YES, list the medications:

_____

What **major illnesses** or **injuries** have you had?

_____

Have you had any **surgeries**?

_____

Do you *currently* have any problems in the following areas? If "YES", Please provide information.

	YES	NO	Explanation of problem
EYES			
GENERAL / CONSTITUTIONAL			
EARS, NOSE, THROAT			
CARDIOVASCULAR			
RESPIRATORY			
GASTROINTESTINAL			
GENITAL, KIDNEY, BLADDER			
MUSCLES, BONES, JOINTS			
SKIN			
NEUROLOGICAL			
PSYCHIATRIC			
ENDOCRINE			
BLOOD, LYMPH			
ALLERGIC, IMMUNOLOGIC			

FAMILY

Any family medical history of eye problems (mother, father, sibling, grandparent)? _____YES _____NO
If YES, describe: (example Glaucoma, Macular Degeneration, Skin cancer)

_____

SOCIAL

What is your occupation?_____
Marital Status (married, divorced, single, widowed)_____
Do you drive? _____YES _____NO
Do you have visual difficulty when driving? _____YES _____NO
Do you have problems with night vision? _____YES _____NO
Do you have problems with glare? _____YES _____NO
Do you drink alcohol? _____YES _____NO If YES: occasional 1 per day 2-3 / day 4+ / day
Do you smoke/use tobacco products? _____YES _____NO If YES: occasional ½ pack/day 1 pack/day 1+ pack

Physician's Signature_____