Miroya J. Monsour, M.D.

Penn Valley Plaza

1075 Harrison City-Export Rd.

Suite 1

Jeannette, PA 15644

724-744-4009

Your appointment is scheduled for_____

Please fill out the enclosed pages.

On the day of your appointment, please bring these forms along with your photo identification, all insurance cards (medical and vision). If you are on any medications, please provide a list of medications.

If you are using vision insurance for eyewear benefits, please know who your vision benefits are covered by. It will be different than your medical insurance.

PATIENT REGISTRATION

NAME_____BIRTHDATE_____AGE_____

ADDRESS_____CITY_____STATE____ZIP_____

HOME PHONE _____ CELL PHONE_____ WORK _____

EMAIL_____

S.S NUMBER_____

MARITAL STATUS_____SPOUSE'S NAME_____

EMERGENCY CONTACT NAME_____PHONE_____

EMPLOYER/NAME/ADDRESS/PHONE_____

WHO IS THE INSURED PARTY ON YOUR INSURANCE POLICY_____

RELATIONSHIP TO PATIENT_____

INSURED'S NAME AND DATE OF BIRTH_____

FOR INSURANCE: I authorize Dr. Miroya Monsour to submit a claim to my insurance carrier or its intermediaries for all covered services rendered by the physician and authorize and direct my insurance carrier or its intermediaries to issue payment check(s) directly to the physician rendering the covered services. Authorize Dr. Miroya Monsour to furnish complete information to my insurance carrier its intermediaries regarding services rendered.

SIGNATURE: DATE:

I understand that it is my responsibility to follow my doctor's advice for the care of my eyes. I also understand that although the management of this office will send me a reminder, it is my responsibility to make follow –up appointments as instructed by the doctor or her assistant.

SIGNATURE_____DATE_____

HIPPA ACKNOWLEDGEMENT

IF YOU WOULD LIKE TO READ THE COMPLIANCE FORM, PLEASE ASK FOR ONE.

I have been offered the HIPPA Form and I have been provided an opportunity to review it.

NAME: _____

SIGNATURE:_____DATE:_____

I also give permission to have my family or P.O.A. receive and look at my records, and to speak to the Doctor or Staff regarding my medical information.

SIGNATURE:_____ DATE:_____

Date:_____

Name:_____ DOB_____

Primary Doctor:_____

Reason for Visit:_____

Occupation:_____

Please fill out this whole sheet

Smoking

Current Smoker ___

Previous Smoker ___

Never Smoked ___

Alcohol

Yes (How Many Per Week) ___

No ___

Eye Medications

_____

_____

_____

_____

_____

_____

_____

Medications

_____

_____

_____

_____

_____

_____

_____

Your Medical History

Diabetes ___

Thyroid ___

High Blood Pressure ___

Heart Attack ___

Blood Disorder ___

Stroke ___

Asthma ___

Arthritis ___

Heart Disease ___

Emphysema ___

Cancer (Form Of)___

C-Dif ___

Oxygen ___

Hepetitis C ___

MRSA___

Pacemaker___

Difibulator ___

C PAP ___

Your Eye History

Cataract ___

Glaucoma ___

Retinal Detachment ___

Macular Degeneration ___

Lazy Eye ___

Eye Injury ___

Diabetic Eye Disease ___

Eye Surgery (Type of) ___

Lasik

PRK

Retinal

Allergies

_____

_____

_____

_____

_____

Family Health History

USE F=Father M=Mother S=Sister B=Brother etc..

Medical

Diabetes ___

Cancer (Form of) ___

High Blood Pressure ___

Blood Disorder ___

Thyroid ___

Asthma ___

Heart Disease ___

Emphysema ___

Stroke ___

Eye

Cataract ___

Glaucoma ___

Retinal Detachment ___

Macular Degeneration ___

Lazy Eye ___

Diabetic Eye Disease ___

Surgical History (NOT EYE SURGERY)

_____

_____

_____

_____

Review of Current Symtoms

Headache___

Migraine___

Dizziness___

Fainting___

Shortness of Breath___

Neurological___

Diabetics Last A1C and Glucose

_____

Would you like a copy of today's visit? Y___ N___

Vision Insurance vs. Medical Insurance

Center for Sight is required by law to follow proper coding and billing for eye/vision examinations. Your vision insurance will not pay for a medical eye condition and your medical insurance will not pay for your routine eye examination.

Vision Plan:

- Provides you with a "well vision" exam
- Pays for an exam if your eyes are healthy, but you suffer from focusing problems like nearsightedness, farsightedness, astigmatism, and presbyopia (the need for reading glasses).
- Will only pay for exam if there is nothing wrong with the health of your eyes.

Medical Plan:

- Will pay for your exam if there is something wrong with the health of your eyes.
- The following conditions are examples: dry eyes, eye allergies, cataracts, contact lens complications/infections, diabetic eye disease, floaters, glaucoma, eye infections, etc.

We are not allowed to bill both medical and vision insurances on the same day. If you have a medical eye problem, and still need glasses, we can handle it one of two ways. We can check your prescription the same day as your medical eye exam and bill you for the refraction (eyeglass prescription check), or you can come back on another day and we can bill your vision insurance for your refraction.

Initials _____

Dilation Policy

It is Dr. Monsour's policy that all new patients will have their pupils dilated as part of their comprehensive eye health and vision examination. Returning patients will be dilated at least every other year, or more frequently as determined by the doctor.

In order for Dr. Monsour to properly assess your eye health, we MUST routinely perform a dilated examination of your eyes. To dilate the eyes, eye drops must be administered that cause the pupil (black part in the center of your eye) to become larger. When the pupils are not dilated, only ~25% of the back of the eye (retina) can be seen, with a dilated eye exam nearly 100% of the retina can be seen. A healthy retina is important to good vision. Dilated eye exams help detect glaucoma, macular degeneration, diabetic eye disease, high blood pressure, retinal detachment, as well as many other conditions. Dilation may cause blurred vision and light sensitivity in some patients for ~4 hours. Blurry vision is typically noticed while reading. We will provide temporary sunglasses for you to use after your dilation. Please note, there is NO additional charge for having your eyes dilated.

Initials _____