DAN LIU, M.D.

SUSAN M. YEOMANS, M.D., P.C.
65 BOSTON POST ROAD WEST
MARLBOROUGH, MA 01752

PHONE: 508-481-0815 FAX: 508-481-0820

Welcome to our office!

As a new patient, we request that you complete the attached paperwork and bring it with you to your scheduled appointment. This will reduce the amount of time you spend in our office. We ask that you arrive 15 minutes before your appointment time in order to get your documents and chart ready. A New Patient exam is an extensive exam which includes having the eyes dilated, and usually lasts 2 hours. If you are being seen for glaucoma or another medical condition which requires more expanded testing, please be aware that this may extend your appointment time. We ask that you consider having someone drive you and wear dark sunglasses, as your vision may be blurry and light-sensitive following the exam, especially if you have never been dilated before. For your exam, please also bring **your prescription eyeglasses and a list of current medications you are taking – including over-the-counter meds.**

Dr. Liu is considered a Specialist. Therefore, if your insurance company requires you to obtain a referral to see a Specialist, please do so **prior** to your visit. We regret that we will not be able to see you without a referral in place (if needed).

If you were referred to our Practice by another eye care provider, or are transferring your ongoing care here, please arrange to have a referral letter and/or records sent to our office prior to your appointment. The release of medical records requires your written/signed consent.

Please contact our Staff with any questions or concerns you may have, so that we can assist you, even in advance of your visit.

Also, please note that our office charges a $25 fee for all missed appointments or test scheduled, as well as those cancelled with less than 24 hour notice. Please keep this in mind if you need to change your appointment.

DAN LIU, M.D.

SUSAN M. YEOMANS, M.D., P.C.

Patient Name: _____

Date of Birth: _____/_____/_____ Marital Status: _____ Male: ____ Female: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____-_____-_____ Work/Cell phone: _____-_____-_____

Employer: _____

Emergency Contact: _____ Phone: _____-_____-_____

Relationship to Patient: _____

Primary Care Physician: _____ Phone: _____-_____-_____

Primary Care Physician Address: _____

_____

Primary Insurance: _____ Policy ID# _____

Subscriber's Name: _____ Subscriber's Date of Birth: _____/_____/_____

Secondary Insurance: _____ Policy ID#_____

I authorize the release of any payment and medical information to process this and any related claims.
I certify that the above information is correct.

Signature: _____ Today's Date: _____

IF the patient is a minor or unable to sign:

I hereby authorize Dan Liu, M.D. to administer such treatment as may be deemed necessary or advisable for the above patient.

Guardian's Signature: _____ Today's Date: _____

Print Name: _____ Relationship: _____

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SIGNATURE ON FILE

Any monies payable will be authorized to **Susan M. Yeomans, M.D., P.C.**

I authorize the release of any medical information to my insurance carrier as requested by them. I permit a copy of this authorization to be used in place of the original.

Patient Signature **Date**

I authorize any medical benefits payable on my behalf to be paid directly to
Susan M. Yeomans, M.D., P.C.

Patient Signature **Date**

I authorize any holder of medical or other information about me to be released to the Social Security Administration and Health Care Financing Administration of its intermediaries or carriers any information needed for this or related to Medicare claim. I permit a copy of this authorization to be used in placed of the original, and request payment of medical insurance benefits either to my myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my health treatment. (Section 1128B of Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information). Regulations pertaining to Medicare assignment of benefits also apply.

Medicare Recipient **Date**

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HIPAA PRIVACY STATEMENT

I, _____acknowledge that a copy of Dr. Liu's
(please print name)

Privacy Notice is available for my review at the front desk.

_____ _____
Patient Signature Date

If a legal guardian is completing this form:

_____ _____
Legal Guardian (please print name) Relationship

_____ _____
Legal Guardian Signature Date

Dan Liu, M.D.

Susan M. Yeomans, M.D., P.C.

Please *initial* each item and sign and date the form below to confirm acknowledgement and understanding of our office policies:

- ____ **Co-Payments.** Payment is due at the time of your visit. We accept cash, check, MasterCard, Visa, Discover and American Express.

- ____ **Routine Exams.** Due to the specialty nature of the practice, most insurance carriers will not cover routine eye exams. At the end of the visit, if the diagnosis is routine (blurred vision, need for glasses, etc.) you will be responsible for payment if the claim is denied by your insurance carrier.

- ____ **Refraction.** If you request a prescription for glasses, it is usually not covered by your insurance carrier, as we do not accept Vision Plans and do not provide routine eye care. You will be responsible for that portion of the exam.

- ____ **Missed/Cancelled Appointment.** We reserve the right to charge $25.00 (per service and diagnostic test scheduled for that visit) for no-shows and appointments cancelled with less than 24 hours' notice. The fee is due before the next appointment can be rescheduled. This fee is your responsibility and is not billable to your insurance carrier. Patients who repeatedly miss appointments or repeatedly reschedule without proper notice may be asked to seek care from another ophthalmology practice.

- ____ **Prescriptions.** Please allow at least two business days for prescription refills. Refills are done electronically at the end of each business day.

- ____ **Medical Records**. If medical records are requested, there is a base fee of $15.00 per request, plus a copying charge of $0.50 per page for the first 100 pages, and $0.25 per page in excess of 100 (per Mass.gov Medical Records Obligations Policy). Please allow up to four weeks from the receipt of your payment for processing.

- ____**Insurance and Contact Information.** It is the patient's responsibility to keep our practice informed about any changes in insurance, address or telephone number(s). We cannot be responsible for undeliverable messages/notices/bills/insurance claims due to incorrect information in our files.

- **Appointments/Delays**. As a specialty practice, we are committed to providing quality and compassionate care to our patients. We will give each patient quality time to ensure that their medical needs and concerns are addressed. As such, it is difficult to predict in advance exactly how much time each patient will require or how many hospital/physician consultations or other emergencies the doctor may be dealing with on any given day. For this reason, we appreciate your patience with any delays you may encounter during your visit with us. If you are late for your appointment and the next patient is already here, you may be asked to wait to be worked back into the schedule or possibly reschedule your appointment.

Patient Signature: _____ **Date:** _____

MEDICAL HISTORY FORM

Please complete all areas below

PRINT NAME:_____**DATE:**_____

Who referred you to our practice?

☐ My Primary Care Physician/ Nurse Practitioner- List name: _____
☐ Another Physician- List name: _____
☐ My Optometrist- List name: _____
☐ A Family Member- List name: _____
☐ A Friend- List name: _____
☐ I found you on the web
☐ An Advertisement- List where: _____

OCULAR HISTORY:

Do you have any of these conditions?			**FAMILY HISTORY:**		
AMBLYOPIA (Lazy Eye)	**Y**	**N**	AMBLYOPIA (Lazy Eye)	**Y**	**N**
GLAUCOMA	**Y**	**N**	GLAUCOMA	**Y**	**N**
RETINAL DETACHMENT	**Y**	**N**	RETINAL DETACHMENT	**Y**	**N**
MACULAR DEGENERATION	**Y**	**N**	MACULAR DEGENERATION	**Y**	**N**
CATARACT	**Y**	**N**	CATARACT	**Y**	**N**
DRY EYES	**Y**	**N**	DRY EYES	**Y**	**N**
DIABETIC RETINOPATHY	**Y**	**N**	DIABETIC RETINOPATHY	**Y**	**N**
EYE INJURY/EYE SURGERY	**Y**	**N**	RETINAL DISEASE	**Y**	**N**

LIST ALL EYE SURGERIES:

LIST ALL OTHER SURGERIES:

DATE OF LAST EYE EXAM:_____ **By Whom?**_____

IF APPLICABLE: PLEASE PROVIDE YOUR CONTACT LENS BRAND AND POWER (LISTED ON BOX- YOU MAY WANT TO GET THIS INFO FROM HOME IF YOU DON'T HAVE IT WHILE YOU ARE WAITING)

RIGHT EYE:_____

LEFT EYE:_____

LIST ANY PROBLEMS WITH CONTACT LENSES:_____

SOCIAL HISTORY: Circle all that apply

SMOKING:	NEVER	CURRENT (no. packs a day)		FORMER
DO YOU DRIVE?		YES	NO	
DO YOU LIVE AT HOME?		YES	NO	
DO YOU LIVE ALONE?		YES	NO WITH SPOUSE/ROOMATE NO AT NURSING HOME	
DO YOU DRINK ALCOHOL		YES	NO	
OCCUPATION?		UNEMPLOYED	YES	NO
IF YOUNGER THAN 18 DO YOU RECEIVE SPECIAL EDUCATION SERVICES?		YES	NO	

YOUR MEDICAL HISTORY

HIGH BLOOD PRESSURE	**Y**	**N**
HEART PROBLEMS	**Y**	**N**
ARTHRITIS RA / OA	**Y**	**N**
LUNG PROBLEMS	**Y**	**N**
STROKE	**Y**	**N**
THYROID PROBLEMS	**Y**	**N**
CANCER	**Y**	**N**
ELEVATED CHOLESTEROL	**Y**	**N**
DIABETES Type 1 OR 2	**Y**	**N**
HOW MANY YEARS_____		
ASTHMA	**Y**	**N**
BLOOD DISORDERS	**Y**	**N**
MIGRAINES	**Y**	**N**
HIV/AIDS	**Y**	**N**
HEPATITIS	**Y**	**N**
PREGNANCY	**Y**	**N**
PROBLEMS W ANESTHESIA	**Y**	**N**

FAMILY MEDICAL HISTORY

HIGH BLOOD PRESSURE	**Y**	**N**
HEART PROBLEMS	**Y**	**N**
ARTHRITIS	**Y**	**N**
LUNG PROBLEMS	**Y**	**N**
STROKE	**Y**	**N**
THYROID PROBLEMS	**Y**	**N**
CANCER	**Y**	**N**
ELEVATED CHOLESTEROL	**Y**	**N**
DIABETES	**Y**	**N**
MIGRAINES	**Y**	**N**
ASTHMA	**Y**	**N**
BLOOD DISORDERS	**Y**	**N**

REVIEW OF SYSTEMS: ***DO YOU HAVE NOW, OR HAVE YOU HAVE YOU EVER HAD ANY OF THE FOLLOWING HEALTH PROBLEMS? (Circle all that apply)***

MUSCULOSKELETAL:	**MUSCLE PAIN**	**BACK PAIN**	**JOINT SWELLING**
ALLERGIC/IMMUNOLOGIC:	**HAY FEVER**	**HAIR LOSS**	**FACIAL REDNESS**
CONSTITUTIONAL:	**WEIGHT LOSS**	**FEVER**	**LOSS OF APPETITE**
EAR, NOSE AND THROAT:	**HEARING LOSS**	**HOARSENESS**	**RINGING IN EARS**
CARDIOVASCULAR:	**CHEST PAIN**	**PALPITATIONS**	**SHORTNESS OF BREATH WHEN SLEEPING FLAT**
RESPIRATORY:	**COUGH**	**WHEEZING**	**SHORTNESS OF BREATH**
GASTROINTESTINAL:	**BLOOD IN STOOL**	**DIARRHEA**	**STOMACH PAIN**
GENITOURINARY:	**PAIN WITH URINATION**	**BLOOD IN URINE**	**GENITAL DISCHARGE**
SKIN:	**SKIN ULCERS**	**SKIN RASH**	**LUMPS**
NEUROLOGY:	**SEIZURES**	**HEAD TREMORS**	**HEADACHES**
PSYCHIATRIC:	**ANXIETY**	**PANIC ATTACKS**	**CLAUSTROPHOBIA**
HEMATOLOGY/LYMPHATIC:	**EASY BLEEDING**	**EASY BRUISING**	

LIST ANY MEDICATION YOU ARE TAKING:	**DOSAGE**	**FREQUENCY**

ALLERGIES TO MEDICATIONS/REACTIONS TOMEDICATIONS: _____

Please provide your Pharmacy name and Address_____

SIGNATURE OF PATIENT/ REPRESENTATIVE: _____ DATE_____

Directions to 65 Boston Post Road WEST, Suite 250

Marlborough, MA 01752

Phone: (508) 481-0815

From Route 495 (North or South): Take Exit 63B towards Northborough/Route 20. Continue straight for a quarter mile. Our office is located on the right as you head down the hill; it is a three-story red brick building JUST after a taller office building called "33 West". The sign says "Marlborough Executive Park". Loop around the parking area counter-clockwise to the front of the building; our office is off the main lobby on the left.

**If you pass the Embassy Suites hotel, you've gone too far.

From Route 20 Eastbound: Once you reach the RK Plaza (Hannaford's grocery store on the left, and Wendy's on the right), continue up the hill, staying in the left hand lane. Make a U-Turn at the intersection at the top of the hill (at Landry Dr. and Glen St. – St. Mary's Credit Union on your left and the 99 Restaurant on your right). Head back down the hill, past the taller office building "33 West"; ours is the next driveway; our building is a three-story red brick building. The sign says "Marlborough Executive Park". Loop around the parking area counter-clockwise to the front of the building; our office is off the main lobby on the left.

**If you pass the Embassy Suites hotel, you've gone too far.

From Route 20 Westbound: Cross over Route 495; then follow directions "From Route 495" above.