Registration: . .

David F. Plotsky, MD, PC

Date	Account ID	Chart ID	Other ID	Internal Use

Patient Information

Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Social Security #
.	.					

Address	Home Phone	Cell Phone
	--	

Address 2	Work Phone	Email Address

City	State	Zip Code	Employer Name & Address	Occupation

Emergency Contact	Pharmacy	Pharmacy Phone

Physician	Referring Physician
David F. Plotsky	

Medical Insurance	Name & Address	Policyholder	Relationship	Policy ID	Group ID
1					
2					
3					

Guarantor (Person to be billed, if different than patient)

1 Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Social Security #

Address	Home Phone	Work Phone	Email Address

City	State	Zip Code	Employer Name & Address	Occupation

2. Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Social Security #

Address	Home Phone	Work Phone	Email Address

City	State	Zip Code	Employer Name & Address	Occupation

HIPAA Approved Contacts

1. Last Name	First Name	Middle	Gender	Birthdate	Social Security #	Relationship

Address	City	State	Zip Code	Home Phone	Cell Phone	Work Phone

2. Last Name	First Name	Middle	Gender	Birthdate	Social Security #	Relationship

Address	City	State	Zip Code	Home Phone	Cell Phone	Work Phone

Patient's or Authorized Person's Signature

I the undersigned give my authorization to treat and assign directly to David F. Plotsky, MD, PC , all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am ultimately financially responsible for all approved and covered charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that payment is expected at the time of service.

I acknowledge receipt of the Practice's Notice of Privacy Practices. I authorize the Practice to use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting healthcare operations.

Signature	Signature Date
X	

David F. Plotsky, MD, PC
6410 Rockledge Drive, Suite 108
Bethesda, MD 20817
Phone: 301-530-6699
Email :

Please attach all pertinent insurance ID cards for photocopying.

David F. Plotsky, MD, PC

Health Questionnaire

Patient Name ______________________ Reviewed by ______________________

Date ______________ Date ______________

Past Medical History			
Any known Medical Problems? ☐ None			
Disease	Yes	No	Comments
High Blood Pressure Heart Disease Stroke Diabetes Insulin Oral meds Kidney Disease Thyroid Disease AIDS/HIV + Hepatitis Other			

Medications
Do you take any medications? ☐ None
Aspirin ☐ Yes ☐ No Blood thinner ☐ Yes ☐ No Other medications: ______________________ ______________________ ______________________ ______________________ ______________________ ______________________

Any previous surgical operations? ☐ Yes ☐ No

Please list any operations:

Are there any known drug allergies? ☐ Yes ☐ No

Please list drug allergies:

Review of Systems Are any of the following symptoms present? ☐ No known problems

General	Yes	No	Neurological	Yes	No	Musculoskeletal	Yes	No
Depression Fever Weight loss/gain			Weakness Paralysis Numbness Headaches			Muscle aches Joint pain Swollen joint		
Ears, Nose, Throat	Yes	No	Respiratory	Yes	No	Skin	Yes	No
Loss of hearing Ringing in ears Sinus Problems Sore throat			Shortness of breath Wheezing Persistent cough			Excessive dryness Rash		
Cardiovascular	Yes	No	Gastrointestinal	Yes	No	Hematological/Lymphatic	Yes	No
Chest pain Irregular heart beat Poor circulation			Stomach pain Diarrhea Vomiting			Bleeding problems Blood transfusions Bruise easily Excessive bleeding with surgery Or dental work		
Genito-urinary	Yes	No						
Blood in urine Pain with urination								

Family History Do blood relatives have any?	
☐ Heart Disease ☐ High blood pressure ☐ Stroke ☐ Diabetes	☐ Kidney disease ☐ Migraine headache ☐ Other ______________

Social History Any history of use of the following?
☐ Alcohol ☐ Tobacco ☐ Illegal drugs ☐ IV drugs

Past Eye History Have any of the following diseases been present?	Past Surgical Eye History Has there been any eye surgery? ☐ None
☐ Cataract ☐ Glaucoma ☐ Diabetic eye disease ☐ Macular degeneration ☐ Ocular misalignment ☐ Blindness ☐ Corneal disease ☐ Other eye disease ______________________	☐ Strabismus (eye muscle) surgery ☐ Cataract surgery ☐ Laser surgery ☐ Other eye surgery ______________________

Current eye medications? ☐ None	Allergic to eye medications? ☐ None known

Eye review of systems. Symptoms ☐ None	Family Eye History ☐ None
☐ Poor night vision ☐ Light sensitivity ☐ Dry Eyes ☐ Excessive tearing ☐ Frequent/forceful blinking ☐ Eye pain (R/L, Both eyes) ☐ Episodic loss of vision	☐ Cataract ☐ Glaucoma ☐ Diabetic eye disease ☐ Macular degeneration ☐ Misaligned eyes (strabismus) ☐ Blindness ☐ Corneal disease ☐ Other eye disease ______________________

David F Plotsky MD PC

Financial Policy

We are committed to providing you with the best service possible. If we participate with your medical insurance provider we will help you receive your benefits. It is your responsibility to verify OUR participation in YOUR current insurance plan and that you have all necessary referrals prior to your scheduled appointment.

NON-COVERED SERVICES:

Most insurance companies select certain services they will not cover such as **refractions, contact lens fittings, annual contact lens evaluations, and normal eye exams.** The term "routine vision exam" is a term created by insurance companies and we do not perform, nor bill, these exams.

Things to bring to each appointment:

- Current Health Insurance card(s)
- Photo ID (If patient is a minor we will need parent photo id)
- Method of payment – we accept cash, visa, & mastercard.

Appointments:

- Please arrive 10 minutes early
- If more than 10 minutes late you will be marked as a No Show. We may need to reschedule your appointment and you agree to pay the fee associated with missing your scheduled appointment.

Missed/ Cancelled Appointments and other fees:

- I agree to pay for visits missed or cancelled within 24 hours/or 1 business day of my scheduled appointment.
- Premium time is charged $75, non-premium appointments are charged $45.
- There is a $40 fee for all checks returned to our office

Payment in full is due at time of service:

- Co-pays, co-insurance, deductibles, and non-covered services are the insured/patient's responsibility and are due during the check-in process.

Collections and outstanding balances

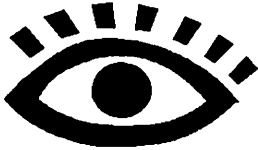
- Billed balances (after insurance processing) are due immediately upon presentation
- Balances over 30 days may incur a $10 statement fee
- All balances are due prior to any further service provided by our office.
- Balances older than 30 days (after insurance processing) may be subject to collection fees of 33% of outstanding balance and interest charges of 2% per month. Balances that reach 60 days past due will be sent to a collection agency and you will be responsible for all collection and legal fees that our office incurs to collect this debt.

I have read and understand these policies set forth by David F Plotsky MD PC and I agree to it's terms.

Patient name______________________ parent/guardian name______________________________

Patient/Parent Signature _______________________________________ Date ________________

Revised 3-2015



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Pediatric Ophthalmology & Adult Strabismus
6410 Rockledge Drive, Suite 108
Bethesda, Maryland 20817
301-530-6699 Fax 301-581-0969
www.docplot.com info@docplot.com

ACKNOWLEDGMENT: RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of Notice of Privacy Practices effective 12/15/13 or have access to the notice on the practice website www.docplot.com.

Name (please print): ________________________________

Signature: ________________________________

Date: ____________________________

I am a parent or legal guardian of ______________________ (patient name). I have received a copy of Notice of Privacy Practices effective 12/15/13

Name (please print): ________________________________
Relationship to Patient: ☐ Parent ☐ Legal Guardian

Signature: ________________________________

Date: ____________________________