Julia Nemiroff, MD

2560 RCA Blvd. Suite 112
Palm Beach Gardens, Fl 33410

JNemiroffMD@gmail.com
Ph: (561) 331-1797
Fax: (561) 331-5073
www.RetEyeClinic.com

Patient Medical History

Date _____

Patient Name _____
(last name) (first name) (middle initial)

Primary Care Physician (Medical Doctor) _____
(last name) (first name)

Telephone of Medical Doctor: (_____)_____ Fax: (_____)_____

Do you have, or have you had in the past, any of the conditions listed below?

	Yes	No		Yes	No
Arthritis	☐	☐	Kidney Disease	☐	☐
Asthma	☐	☐	Nervous Problem	☐	☐
Chronic Lung Disease	☐	☐	Sinus Problems	☐	☐
Diabetes	☐	☐	Stomach Problems	☐	☐
Emphysema	☐	☐	Thyroid Problems	☐	☐
Heart Disease	☐	☐	Tuberculosis	☐	☐
Hepatitis	☐	☐	Urinrary Tract Infections	☐	☐
Hernias	☐	☐	Other Infectious Idseases	☐	☐
High Blood Pressure	☐	☐	Others: _____		

Do you smoke? ☐ Yes ☐ No Did you ever smoke? ☐ Yes ☐ No # of yrs smoked ____

Are you allergiec to any medications? ☐ Yes ☐ No If yes, what? _____

Do you suffer from any easonal allergies? ☐ Yes ☐ No If yes, what? _____

Please list all medications, eye drops, and vitamins you are currently taking and the dosage of each.

_____ _____

_____ _____

_____ _____

Do you or your family have any history of the following:

	Yes	No	Self/Relationship to you		Yes	No	Self/Relationship to you
Blindness	☐	☐	_____	Cataracts	☐	☐	_____
Lazy Eye	☐	☐	_____	Eye Disease	☐	☐	_____
Glaucoma	☐	☐	_____	Vascular Disease	☐	☐	_____

List all of the surgeries you have had in the past 10 years: _____

_____

Do you have a living will? ☐ Yes ☐ No _____

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Patient Demographic / Insurance Information

Name _____ Birthdate _____

Address _____

City _____ State_____ Zip _____

Home Phone _____ Cell Phone _____

Work Phone _____ E-Mail _____

Referred by: _____

Primary Care Physician _____ Phone Number _____

Primary Insurance: _____

ID#: _____ GRP# _____

Insured Name: _____ DOB: _____

Secondary Insurance: _____

ID#: _____ GRP# _____

Insured Name: _____ DOB: _____

Emergency Contact Info

Name: _____

Cell Phone: _____

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Signature on File, Assignment of Benefits, Financial Agreement

Printed Patient Name: _____

Date of Birth: _____

MEDICARE: I request that payment of authorized Medicare benefits be made on my behalf to Julia Nemiroff, MD PLLC for services rendered to me. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine benefits payable for services rendered. I understand my signature requests that payment be made and authorizes release of medical information necessary for processing and reimbursement of claims. If another health insurance provider is listed as a Secondary Insurance (Item #9 of the HCFA 1500 claim form), my signature likewise authorizes release of the information to the insurer shown. Julia Nemiroff, MD PLLC accepts the charge determination of Medicare, and I am financially responsible for coinsurance, deductibles and non-covered services.

OTHER INSURANCE: I request that payment of authorized benefits be made on my behalf to Julia Nemiroff, MD PLLC for services rendered to me. I authorize any holder of medical information about me to release to my insurance provider any information needed to determine benefits payable for services rendered. I understand my signature requests that payment be made and authorizes release of medical information necessary for the processing and reimbursement of claims.

FINANCIAL AGREEMENT: I agree that in return for the services provided by Julia Nemiroff, MD PLLC I will pay my account at the time service is rendered or will make arrangements to honor my financial obligations that are satisfactory to the practice. Most insurance companies require the beneficiary to pay co-payments and deductibles at the time of service without exception. I recognize that it is not in the power of Julia Nemiroff, MD PLLC to waive beneficiary co-payments and deductible balances. I understand that I am primarily responsible for the payment of any services not covered by my insurance.

_____ _____

Signature of patient or authorized representative

Date

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HIPAA Privacy Authorization Form

I authorize Dr. Julia Nemiroff of the Retina and Eye Clinic (Julia Nemiroff, MD PLLC) to use and disclose my protected health information (PHI). *Note: Uses and disclosure for Treatment Records, Payment Information, and Healthcare Operations may be permitted without prior consent in an emergency.*

This authorization for release of information covers the period of healthcare from all past, present, and future periods.

This PHI may be used for medical treatment or consultation, billing or claims payment, or other purposes deemed necessary by Dr. Nemiroff.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____

Printed name of patient | Date of Birth

_____ _____

Signature of patient or authorized representative | Date

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Request for Medical Records

To Whom It May Concern:

I hereby authorize the practice to release my existing medical information and records to Julia Nemiroff, MD of the Retina and Eye Clinic (Julia Nemiroff, MD PLLC) for the continuation of my care.

Please forward my records to:
2560 RCA Blvd. Suite 112
Palm Beach Gardens, Fl 33410
Fax: (561)331-5073

Date(s) of Service: _____

I understand that this authorization is valid for one (1) year or revoked through written notice to the Medical Records department of the practice.

Signature of patient: _____

Printed name: _____

Date of Birth:_____

Date: _____

Julia Nemiroff, MD
Retina and Eye Clinic