Joanna M. Fisher, M.D.
Comprehensive Ophthalmology
Cataract Surgery

Jody R. Piltz-Seymour, M.D.
Glaucoma Care Center
Glaucoma & Cataract Surgery

Alessandra K. Intili, M.D.
Comprehensive Ophthalmology
Oculoplastic & Reconstructive Surgery

Valley Eye Professionals, LLC

Colleen P. Halfpenny, M.D.
Comprehensive Ophthalmology
Cornea & Refractive Surgery
Uveitis

David D. DiFranceisco, O.D.
Comprehensive Optometry

Dion R. Ehrlich, M.D.
Comprehensive Ophthalmology

Welcome to Valley Eye Professionals!

Dear Patient,

Welcome to Valley Eye. We are happy you chose us for your eye care. Our goal is to provide the highest quality eye care we can for you. Everything we do here is geared towards that goal.

We are in the process of upgrading our computer system, which will require our **new and established** patients to fill out paperwork to make sure we have the most up to date information. This may add on additional time to your visit. You should plan to be here for 1 ½ to 2 ½ hours, depending on the complexity of your eyes and to account for filling out paperwork, your exam, possible dilation, tests, and/or procedures.

Please bring with you for every appointment:

- Your Driver's license or photo ID
- Your current insurance cards
- Co-payments
- List of current meds
- Your glasses
- A Mask

Our Doctors at Valley Eye are trained in the diagnosis and treatment of all eye diseases. Our doctors specialize in diseases of the cornea, uveitis, glaucoma, cataract, dry eye, and oculoplastics. We also have optometrists on staff who perform routine eye exams as well as contact lens fittings. We also offer Lasik and PRK procedures to qualified patients. Our Ophthalmologists are on staff at local facilities and are also affiliated with Wills Eye Hospital.

Optical Shop: Our optical shop will be able to help you get whatever you need after you get your prescription for eyeglasses or contact lenses. We have a large variety of eyewear for all ages. Our opticians are experts and are always happy to help select the best eyewear for you.

Vision of Beauty at Valley Eye: Offers the latest in rejuvenating skin care products and cosmetic procedures including Botox and fillers. Please let our Doctors know if you have any interest in learning more about this.

Please fill out all attached forms. Please bring with you to your appointment if your visit is in less than 2 weeks. If it is later than 2 weeks, please mail to the address listed below.

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

The Doctors and Staff of Valley Eye Professionals

2755 Philmont Avenue, Suite 140 • Huntingdon Valley, PA 19006
(215) 938-7878 • fax (215) 938-7985 • www.ValleyEyePros.com

VALLEY EYE PROFESSIONALS

BACK **Patient Registration** **Complete Front & Back of Form**

AUTHORIZATION FOR USE OF DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize my physician and/or administrative and clinical staff of Valley Eye Professionals, LLC to disclose general medical information and other protected health information to the following persons and/or entities listed below. If no one is listed below, protected health care information will not be disclosed except in those situations described in the Notice of Privacy Practices.

Name and Relationship of person(s) who you wish to allow access: (e.g., your spouse, son, daughter, sibling, caretaker, friend)

Name of Person or Entity:_____

Phone #: _____ Relationship:_____

Name of Person or Entity:_____

Phone #: _____ Relationship:_____

_____

_____

Please sign **ALL** marked (**X**) Signature lines listed below. **DATE:**_____

I can request a copy of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to read and understand and consent to use and disclosure of protected health information about myself for treatment, payment and health care operations.

X_____ Signature of the Patient or Patient Representative

I have been provided a copy of the Financial Policy to read. I understand, that I, the patient or the patient's representative, am/is responsible for payment of all charges for services rendered. I also acknowledge that non-payment of my account may result in collections proceedings and dismissal from the practice.

X_____ Signature of the Patient or Patient Representative

I authorize the release of any medical information necessary to process all claims and I authorize the release of payment for medical benefits to my insurance carrier(s).

X_____ Signature of the Patient or Patient Representative

If signed by Patient Representative please list name of representative: _____

Please inform the receptionist if you would like a copy of the Notice of Privacy Practices.

CHART NUMBER: _____ **VALLEY EYE PROFESSIONALS**

FRONT **Patient Registration** **Complete Front & Back of Form**

LAST NAME: _____ FIRST NAME: _____ M.I. _____

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____ SEX _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PRIMARY PHONE: _____ DAY PHONE: _____

EMAIL: _____ OCCUPATION: _____

EMPLOYER: _____ WORK PHONE _____

RACE: _____ ETHNICITY: _____ PREFERRED LANGUAGE: English or _____

APPOINTMENT REMINDER PREFERENCE:(CIRCLE ONE) Voice Text Email

EMERGENCY CONTACT: _____ EMERGENCY PHONE #: _____

EMERGENCY RELATIONSHIP: _____

MARITAL STATUS: (CIRCLE ONE) Single Widow/Widower Married Name of Spouse: _____

INSURANCE(S) (Bring your card(s) on day of your visit)

PRIMARY PLAN: _____ ID# _____

SUBSCRIBER NAME: _____ SUB DOB: _____

RELATIONSHIP TO PATIENT: _____ EFFECTIVE DATE: _____

SECONDARY PLAN: _____ ID# _____

SUBSCRIBER NAME: _____ SUB DOB: _____

RELATIONSHIP TO PATIENT: _____ EFFECTIVE DATE: _____

PHARMACY

LOCAL FOR PICKUP: _____ PHONE #: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

MAIL ORDER PHARMACY: _____

PRIMARY, REFERRING, AND SPECIALIST PHYSICIANS

PRIMARY: _____ PHONE #: _____

REFERRING DR: _____ PHONE #: _____

SPECIALIST(S): _____ PHONE #: _____

_____ PHONE #: _____

VALLEY EYE PROFESSIONALS

MEDICAL HISTORY

LAST NAME: _____ **FIRST NAME:** _____ **M.I.** _____

SOCIAL HISTORY (circle)

Drive No Yes
Smoke No Current Every Day Former
Alcohol No Occas/Social 1-2 Drinks/Day 3-4 Drinks/Day

FAMILY HISTORY OF (circle) Relationship

Diabetes Y N _____
Glaucoma Y N _____
Macular Degeneration Y N _____

MEDICAL HISTORY

(Please Check off if you have any of the following conditions)

- ☐ AFIB
- ☐ Arthritis/Musculoskeletal
- ☐ Asthma/Emphysema
- ☐ Cancer
- ☐ Cholesterol
- ☐ Depression/Anxiety
- ☐ Diabetes Type: _____
- ☐ Fallen in Past Year?
- ☐ Hard of Hearing
- ☐ Heart Disease
- ☐ Hematologic
- ☐ High Blood Pressure
- ☐ G.I. Disorder

Diabetes Onset Year: _____

- ☐ Kidney Disease
- ☐ Migraine
- ☐ Neurologic/CVA
- ☐ Shingles
- ☐ Sinus Infections
- ☐ Skin Disorder/Rosacea
- ☐ Sleep Apnea
- ☐ Thyroid

☐ Other: _____

- ☐ Flu Shot Received Date Received _____
- ☐ Pneumococcal Vaccine Date Received _____
- ☐ Covid Shot Received Date Received _____ Type _____

ALLERGIES

☐ Drug List _____
☐ Seasonal Other _____

OCULAR HISTORY

Glaucoma Y N Macular Degeneration Y N Dry Eye Y N Amblyopia Y N
Cataract Y N Retinal Disorder Y N Eye Injury Y N

Ocular Surgery/Laser: _____

MEDICATIONS

List Eye Drops or Eye Medications _____

List All Non Eye Medications _____

LIST ALL SURGERIES (Except Eyes)