Patient History & Physical

Patient Name: _____ **DOB:** _____ **Patient ID:** _____

GENERAL HEALTH

Height _____ ft _____ in
Weight _____ lbs
Recent/Current illnesses, injuries, accidents: _____

Emergency Contact/Release of information:

_____

_____

_____

Name / Relationship / Phone Number

SURGICAL HISTORY

			Side / Location:
Gallbladder Removal	☐ NO	☐ YES	_____
Appendectomy	☐ NO	☐ YES	_____
Orthopedic Surgery	☐ NO	☐ YES	_____
Oral Surgery	☐ NO	☐ YES	_____
Hernia	☐ NO	☐ YES	_____
Tonsillectomy	☐ NO	☐ YES	_____
Spinal Surgery	☐ NO	☐ YES	_____
Hysterectomy	☐ NO	☐ YES	_____
Mastectomy	☐ NO	☐ YES	_____
Amputations	☐ NO	☐ YES	_____

Other: _____

OCULAR SURGICAL HISTORY

			Year
PK Surgery	☐ NO	☐ YES	_____
LASIK Surgery	☐ NO	☐ YES	_____
PRK Surgery	☐ NO	☐ YES	_____
Cataract Surgery	☐ NO	☐ YES	_____
Pterygium Surgery	☐ NO	☐ YES	_____
Glaucoma Laser	☐ NO	☐ YES	_____
Glaucoma Tube Shunt Placement	☐ NO	☐ YES	_____
Glaucoma Trabeculectomy	☐ NO	☐ YES	_____
Retinal Injections (for Macular Degener.)	☐ NO	☐ YES	_____
Retinal Injections (for Diabetic Retinopathy)	☐ NO	☐ YES	_____
Retinal Laser	☐ NO	☐ YES	_____
Retinal Detachment Repair	☐ NO	☐ YES	_____
Oculoplastic Surgery (please select/circle)	☐ NO	☐ YES	_____

Blepharoplasty / Ptosis / Ectropion / Entropion / DCR / MOHS

Other: _____

ASSISTIVE DEVICE

Able to position self with minimal assistance ☐ NO ☐ YES Note: _____

Have you ever or are you currently using:

Wheelchair	☐ NO	☐ YES
Walker	☐ NO	☐ YES
Cane	☐ NO	☐ YES
Dentures	☐ NO	☐ YES
Hearing aids	☐ NO	☐ YES

Other: _____

OCULAR HISTORY

Last Eye Exam: ☐ Never ☐ Date: _____
Last Dilated Exam: ☐ Never ☐ Date: _____

☐ Wears glasses ☐ NO ☐ YES
☐ Wears contact lenses ☐ NO ☐ YES ☐ Soft contacts ☐ Hard contacts Contact lens solution: _____

Patient Conditions: ☐ None ☐ Cataract ☐ Corneal disorder ☐ Dry eyes ☐ Eye inflammation ☐ Eye turn ☐ Glaucoma
☐ Lazy eye ☐ Macular degeneration ☐ Narrow angles ☐ Retinal disorder ☐ Trauma

Eye Prosthesis: ☐ None ☐ Right eye ☐ Left eye ☐ Both eyes Note: _____

CARDIOVASCULAR HISTORY

Heart Attack ^	☐ NO	☐ YES	_____
Cardiac Catheterization ^	☐ NO	☐ YES	_____
Cardiac Stent ^	☐ NO	☐ YES	_____
Bypass/CABG ^	☐ NO	☐ YES	_____
Pacemaker ^	☐ NO	☐ YES	_____
Automatic Internal Defibrillator ^	☐ NO	☐ YES	_____
Congestive Heart Failure ^	☐ NO	☐ YES	_____
Arrhythmia (Afib, Aflutter, etc) ^	☐ NO	☐ YES	_____
Coronary Artery Disease	☐ NO	☐ YES	_____
Valvular Heart Disease	☐ NO	☐ YES	_____
Hypertension/High Blood Pressure	☐ NO	☐ YES	_____
High Cholesterol	☐ NO	☐ YES	_____

Other: _____

RESPIRATORY HISTORY

COPD ^	☐ NO	☐ YES	O2 saturation: _____
Tuberculosis ^	☐ NO	☐ YES	Year: _____
Sleep Apnea	☐ NO	☐ YES	☐ **CPAP ^** ☐ **BIPAP ^**
Emphysema ^	☐ NO	☐ YES	
Continuous Oxygen ^	☐ NO	☐ YES	O2 saturation: _____
			# L/min: _____
			☐ Supine position tolerated above O_2 saturation 90
Asthma	☐ NO	☐ YES	
Shortness of Breath	☐ NO	☐ YES	
Chronic Cough	☐ NO	☐ YES	

Other: _____

Patient Name: _____ **DOB:** _____ **Patient ID:** _____

NEUROLOGICAL HISTORY

Stroke/TIA ^	☐ NO	☐ YES	Year: _____
Alzheimer's	☐ NO	☐ YES	
Parkinson's	☐ NO	☐ YES	
Dementia	☐ NO	☐ YES	
Multiple Sclerosis	☐ NO	☐ YES	
Epilepsy/Seizures	☐ NO	☐ YES	
Restless Leg Syndrome	☐ NO	☐ YES	
Headaches	☐ NO	☐ YES	
Migraines	☐ NO	☐ YES	
Vertigo	☐ NO	☐ YES	
Numbness	☐ NO	☐ YES	
Fainting/LOC	☐ NO	☐ YES	

Other: _____

HEMATOLOGICAL HISTORY

Hepatitis C ^	☐ NO	☐ YES	
Blood Clots ^	☐ NO	☐ YES	
Bleeding Tendencies ^	☐ NO	☐ YES	
Blood Thinners ^	☐ NO	☐ YES	_____
Anemia	☐ NO	☐ YES	
Blood Transfusions	☐ NO	☐ YES	Year: _____

Other: _____

AUTOIMMUNE DISEASE HISTORY

Sjogren's Syndrome	☐ NO	☐ YES
Rheumatoid Arthritis	☐ NO	☐ YES
Lupus	☐ NO	☐ YES

Other: _____

ENDOCRINE HISTORY

Diabetes	☐ NO	☐ YES	Type: _____
			Year diagnosed: _____
			HbA1c: _____
			Last Blood Sugar: _____
Hypothyroidism	☐ NO	☐ YES	
Hyperthyroidism	☐ NO	☐ YES	

Other: _____

INFECTION HISTORY

HIV/AIDS ^	☐ NO	☐ YES	
MRSA	☐ NO	☐ YES	Year diagnosed: _____
			Year resolved: _____
Staph Infection	☐ NO	☐ YES	Year diagnosed: _____
			Year resolved: _____
Pseudomonas	☐ NO	☐ YES	Year diagnosed: _____
			Year resolved: _____

Other: _____

SKIN/INTEGUMENTARY HISTORY

Shingles	☐ NO	☐ YES	Location: _____
			Last outbreak: _____
Eczema	☐ NO	☐ YES	
Rashes	☐ NO	☐ YES	
Wounds	☐ NO	☐ YES	

Other: _____

MUSCULOSKELETAL HISTORY

			Location
Metal Implant/Prosthetic	☐ NO	☐ YES	_____
Arthritis/Osteoarthritis	☐ NO	☐ YES	
Joint Aches, Pain, Swelling	☐ NO	☐ YES	
Stiffness/Contractures	☐ NO	☐ YES	
Paralysis	☐ NO	☐ YES	_____

Other: _____

PSYCHIATRIC HISTORY

Anxiety	☐ NO	☐ YES
Depression	☐ NO	☐ YES
Memory Loss	☐ NO	☐ YES

Other: _____

EAR, NOSE, THROAT HISTORY

Hearing Impaired	☐ NO	☐ YES
Dry Mouth	☐ NO	☐ YES
Sinus Issues	☐ NO	☐ YES

Other: _____

GASTROINTESTINAL HISTORY

GI Bleed	☐ NO	☐ YES
Jaundice	☐ NO	☐ YES
Liver Disease	☐ NO	☐ YES
GERD	☐ NO	☐ YES
Ulcers	☐ NO	☐ YES
Nausea/Vomiting	☐ NO	☐ YES

Other: _____

KIDNEY (RENAL) HISTORY

Dialysis ^	☐ NO	☐ YES	_____
Shunt/Fistula	☐ NO	☐ YES	Location: _____
Kidney Stones	☐ NO	☐ YES	
Kidney Disease	☐ NO	☐ YES	
Prostate Problem	☐ NO	☐ YES	
Incontinence	☐ NO	☐ YES	

Other: _____

WOMEN'S HEALTH

Last Menstrual Cycle (LMP): _____	☐ N/A		
or Postmenopausal	☐ NO	☐ YES	
or Hysterectomy	☐ NO	☐ YES	
Pregnant	☐ NO	☐ YES	_____
Breastfeeding	☐ NO	☐ YES	

Other: _____

Patient Name: _____ **DOB:** _____ **Patient ID:** _____

MISCELLANEOUS HISTORY

Malignant Hyperthermia ^ ☐ NO ☐ YES Year: _____

☐ Dark/chocolate colored urine
☐ Family history of unexpected death(s) following general anesthesia or exercise
☐ Personal history of muscle spasm
☐ Family/personal history of MH
☐ High temperature following exercise
☐ Muscle/neuromuscular disorder
☐ Unanticipated fever immediately following anesthesia

Organ Transplant ^ ☐ NO ☐ YES Year: _____ Type: _____

Reaction to Local Anesthesia/ IV Sedation ☐ NO ☐ YES ☐ Nausea ☐ Vomiting ☐ Fever ☐ Swelling ☐ Anaphylaxis ☐ Difficulty arousing after sedation

History of Cancer ☐ NO ☐ YES Year: _____ Type: _____ Site: _____ Year resolved: _____

Latex Allergy ☐ NO ☐ YES

Other: _____

FAMILY HISTORY

Heart Trouble	☐ N/A	☐ Mother	☐ Father	☐ Grandparent	☐ Siblings	Note: _____
High Blood Pressure	☐ N/A	☐ Mother	☐ Father	☐ Grandparent	☐ Siblings	Note: _____
Liver Problems	☐ N/A	☐ Mother	☐ Father	☐ Grandparent	☐ Siblings	Note: _____
Kidney Problems	☐ N/A	☐ Mother	☐ Father	☐ Grandparent	☐ Siblings	Note: _____
Bleeding Disorders	☐ N/A	☐ Mother	☐ Father	☐ Grandparent	☐ Siblings	Note: _____
Cancer	☐ N/A	☐ Mother	☐ Father	☐ Grandparent	☐ Siblings	Note: _____
Stroke	☐ N/A	☐ Mother	☐ Father	☐ Grandparent	☐ Siblings	Note: _____
Lung Problems	☐ N/A	☐ Mother	☐ Father	☐ Grandparent	☐ Siblings	Note: _____
Blindness	☐ N/A	☐ Mother	☐ Father	☐ Grandparent	☐ Siblings	Note: _____
Cataract	☐ N/A	☐ Mother	☐ Father	☐ Grandparent	☐ Siblings	Note: _____
Corneal Disorders	☐ N/A	☐ Mother	☐ Father	☐ Grandparent	☐ Siblings	Note: _____
Genetic Disorders	☐ N/A	☐ Mother	☐ Father	☐ Grandparent	☐ Siblings	Note: _____
Eye Turn	☐ N/A	☐ Mother	☐ Father	☐ Grandparent	☐ Siblings	Note: _____
Glaucoma	☐ N/A	☐ Mother	☐ Father	☐ Grandparent	☐ Siblings	Note: _____
Lazy Eye	☐ N/A	☐ Mother	☐ Father	☐ Grandparent	☐ Siblings	Note: _____
Macular Degeneration	☐ N/A	☐ Mother	☐ Father	☐ Grandparent	☐ Siblings	Note: _____
Retinal Disorder	☐ N/A	☐ Mother	☐ Father	☐ Grandparent	☐ Siblings	Note: _____
Diabetes	☐ N/A	☐ Mother	☐ Father	☐ Grandparent	☐ Siblings	Note: _____

Other: _____

SOCIAL HISTORY

Occupation ☐ Employed ☐ Unemployed ☐ Retired ☐ Disabled Note: _____

Smoking ☐ Never smoked ☐ Cigarette smoker ☐ Cigar smoker ☐ Tobacco smoker ☐ Vape smoker
☐ Former smoker Type: _____ Frequency: _____ Note: _____

Alcohol ☐ Never drank alcohol or Type: _____ Frequency: _____

Recreational Drug Use ☐ NO or Type: _____ Method of use: _____

Other: _____

Patient Signature: _____ **Date:** _____

Physician Signature: _____ Date: _____

Technician name: _____ Date: _____
Person responsible for transferring medical history into IMS

After reviewing on DOS, health changes in the past 30 days noted ☐ NO ☐ YES See note in EMR

Physician Signature / Date & Time _____ **Nurse Signature / Date & Time** _____

After reviewing on DOS, health changes in the past 30 days noted ☐ NO ☐ YES See note in EMR

Physician Signature / Date & Time _____ **Nurse Signature / Date & Time** _____

PATIENT NAME: _____ **DOB:** _____ **PATIENT ID:** _____

PATIENT MEDICATION & ALLERGY CHART

The nurse will review this information with you during the admissions process.

✱ - Taken TODAY (*Surgery Center Staff ONLY*)

Do you take any of these medications? If YES, please use checkbox and indicate *DAY OF WEEK*.

Most Common GLP-1 agonists:

☐ NO	☐ YES	Dulaglutide (**Trulicity**) - ***weekly***	_____
☐ NO	☐ YES	Exenatide (**Byetta**) - twice daily	_____
☐ NO	☐ YES	Exenatide Extended Release (**Bydureon BCise**) - ***weekly***	_____
☐ NO	☐ YES	Liraglutide (**Victoza, Saxenda, Xultophy**) - daily	_____
☐ NO	☐ YES	Lixisenatide (**Adlyxin**) - daily	_____
☐ NO	☐ YES	Semaglutide (**Ozempic**) - ***weekly***	_____
☐ NO	☐ YES	Semaglutide (**Rybelus**), oral - daily	_____
☐ NO	☐ YES	Semaglitude (**Wegovy**) - ***weekly***	_____
☐ NO	☐ YES	Tirzepatide (**Mounjaro**) - ***weekly***	_____

Most Common SGLT2 agonists:

☐ NO	☐ YES	Canagliflozin (**Invokana**)
☐ NO	☐ YES	Dapagliflozin (**Farxiga**)
☐ NO	☐ YES	Empagliflozin (**Jardiance**)
☐ NO	☐ YES	Empagliflozin / linagliptin (**Glyxambi**)
☐ NO	☐ YES	Canagliflozin / metformin (**Invokamet, Invokamet XR**)
☐ NO	☐ YES	Dapagliflozin / saxagliptin (**Qtern**)
☐ NO	☐ YES	Empagliflozin / metformin (**Synjardy**)
☐ NO	☐ YES	Empagliflozin / linagliptin / metformin (**Trijardy XR**)
☐ NO	☐ YES	Dapagliflozin / metformin (**Xigduo**)
☐ NO	☐ YES	Ertugliflozin (**Stegltro**)
☐ NO	☐ YES	Ertugliflozin / metformin (**Segluromet**)
☐ NO	☐ YES	Ertugliflozin / sitagliptin (**Steglujan**)

MEDICATIONS / SUPPLEMENTS	**DOSAGE**	**FREQUENCY**

☐ **See Attached List**

ALLERGIES

Please list **ALL ALLERGIES**, including **medications**, **food**, and **latex**, and the reaction they cause.

ALLERGEN	**REACTION**

PREFERRED PHARMACY: _____

Name

_____

Address (Street, City, Zip) / Phone Number

PATIENT SIGNATURE: _____ **DATE:** _____

MILAN EYE CENTER

OFFICE: 678.381.2020 FAX: 678.381.2015

ALPHARETTA | BUFORD | CANTON | CUMMING | DAWSONVILLE | JOHNS CREEK | MARIETTA | SNELLVILLE

PREFERRED EYE CARE PARTNER OF THE ATLANTA BRAVES

New Patient Consents and General Information

I. Consent for Treatment

I hereby voluntarily consent to receive outpatient medical care from Milan Eye, LLC d/b/a Milan Eye Center, and its affiliated entities (collectively and henceforth, "Milan EC") providers and medical staff, including routine examinations, diagnostic procedures, and medical treatment such as laboratory work and the administration of prescribed medications. In connection with such treatment, I understand and agree to each of the following:

(1) Health care workers in general are at risk for exposure to blood and/or bodily fluids thereby increasing their risk of contracting Hepatitis B, Hepatitis C, HIV, and other viral diseases. In the event an exposure occurs during my medical treatment, I understand the need to test me for these diseases and I hereby agree to such testing, both for my own health and safety and that of the Milan EC staff. I understand that this consent will be valid and remain in effect as long as I remain a patient of Milan EC or until I revoke my consent in writing.

(2) Milan EC contracts with certain laboratories (the "Lab Companies") and I am entitled to know which specific Lab Companies it uses. If my condition warrants cultures to be taken for treatment purposes, Milan EC utilizes a third-party facility for processing such cultures (the "Culture Processing Facility"). My healthcare insurer may not cover healthcare claims, in whole or in part, from the Lab Companies and/or the Culture Processing Facility. I fully understand and will adhere to Milan EC's financial policy and will be solely responsible for any costs not otherwise covered by my insurance. Any billing questions I may have for the Culture Processing Facility are my responsibility to address directly with the Culture Processing Facility.

(3) No guarantees have been made to me as to the effect of such examinations or treatment to my condition.

(4) My pupils may be dilated during my appointment. Dilation and other eye drops used during the visit may cause short-term light sensitivity and blurry vision.

Consent for Treatment of Minors

A minor child needs a Patient Agreement signed by a parent or legal guardian. By signing the Agreement, the parent or guardian assumes responsibility for information on behalf of the patient. Milan EC requires a parent or guardian to accompany a minor to all appointments. If, however, a parent or guardian is unable to accompany a minor to an appointment, they must provide verbal consent for treatment beforehand and designate an individual(s) to make financial arrangements/payments on the minor child's behalf. Milan EC reserves the right to request identification of any individual accompanying a minor.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

II. Communication

(1) Personal communications
I authorize Milan EC to call, leave voicemails, and/or send text messages to the phone number(s) I have provided.

(2) Power of Attorney
Patients who elect to utilize a duly authorized legal representative pursuant to a Power of Attorney at their medical visit (the "POA Representative") must provide the appropriate documentation. For patient safety and compliance regarding patient care, the POA Representative will need to provide a copy of the requisite POA document for Milan EC to keep on file. This documentation is required for the POA Representative to make any medical decisions on behalf of the patient and to sign any documents on behalf of the patient. We require any patient who is seen at our facility through a nursing home, rehab center, or assisted living facility to have their POA Representative present for their visit. Without a POA Representative present, we will not be able to see you at your scheduled appointment.

Any patient that elects to utilize a Power of Attorney during their medical visit must provide the appropriate documentation. We require any patient who is seen at our facility through a nursing home, rehab center, or assisted living facility to have their Power of Attorney present for their visit. Without a POA present, we will not be able to see you at your scheduled appointment.

(3) Disclosure of Protected Health Information (PHI) to Specific Individuals
I authorize disclosure of my health information, including appointment and billing information, to the following individual(s) involved in my care and the coordination of my care.

Spouse / Significant Other: _____ Phone Number(s): _____

Parent / Guardian: _____ Phone Number(s): _____

Child / Children: _____ Phone Number(s): _____

Other: _____ Phone Number(s): _____

(4) Release of Protected Health Information to Third Party Agents
I authorize Milan EC and any third party agent debt collector working on behalf of Milan EC, and their respective vendors and business associates including but not limited to third party mailing companies, to utilize all contact information I have provided to communicate with me. This includes, but not limited to, home

telephone, cellular telephone, and employment telephone. I grant consent for Milan Eye Center and third-party collection agents working on behalf of Milan EC, to leave voice and/or text messages on my home telephone, cellular telephone, and employment telephone.

A release may be revoked by me in writing at any time. For medical records questions, please contact Milan EC at (678) 381-2020.

Notice of Privacy Practices

I acknowledge receipt of Milan Eye Center's privacy practices (the "Notice of Privacy Practices"), a copy of which is also available on its website and upon request at the front desk.

_____ _____

Signature of Patient/Authorized Representative *Date*

Photo Consent

Medical photographs may be taken before, during or after a surgical procedure or treatment and consent is required to take such photographs. I understand that I will not be entitled to monetary payment or any other consideration as a result of any use of these images. I authorize Milan Eye Center, and/or associates or licensees to take pre-operative, intra-operative, and post-operative photographs, as well as consent to photographs of my interview and authorize Milan Eye Center, and/or associates or licensees to use pre-operative, intra-operative, and post-operative photographs for professional medical purposes deemed appropriate, including but not limited to submission to my insurance company, medical education, patient education, lay publication, or lectures to medical or lay groups.

Payment for Services

I authorize that payment of authorized Medicare, Medigap, Medicaid or any other insurance be made on my behalf to Milan EC for any services furnished to me by a provider. I authorize any holder of medical information about me to release such information to the Centers for Medicare and Medicaid Services (CMS) and other insurers and their agents to the extent necessary to determine benefits payable for related services. I authorize Milan EC to share my debt-related data with any third-party debt collector and/or letter preparation vendor with respect to any outstanding debt owed to Milan EC.

I understand that it is my responsibility to confirm specific health plan coverage and benefit levels and that I am personally responsible for and agree to pay any charges for care rendered to me not covered by insurance. I agree that for services rendered to me by Milan EC, I will pay my account at the time of service or when invoiced secondary to insurance claim processing. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Milan EC at the time of service. If my account is sent to a collection agency, I agree to pay collection expenses. I also understand that a $25.00 fee may be applied for any returned checks.

I understand that if my health care plan requires an insurance referral to see an ophthalmology specialist, I (i) am responsible for obtaining the documentation prior to my appointment at Milan EC, and (ii) coordinate all required referrals with my primary care physician and submit same to Milan EC at least 48 hours prior to my scheduled appointment.

I understand that if surgical intervention and corresponding anesthesia services are recommended through a Milan EC affiliated ambulatory surgery center, my network status, benefits, and/or out-of-pocket expenses may change.

(1) Minor Patients
The adult accompanying a minor and/or the parents or guardians are responsible for the full payment when services are rendered. For unaccompanied minors, non-emergency treatment will be denied.

(2) Self Pay Patients
For patients who do not have insurance, we do offer a self-pay rate for services. We require a minimum of $300.00 upon check-in at your visit. Any additional cost for the visit will be due at time of check-out. I understand that a Good Faith Estimate ("GFE") of expected charges is available upon scheduling an item or service or upon my request.

(3) Financing Options
We have several financing options available. Such options include Care Credit, Wells Fargo, and Alphaeon.
Please contact our business office for details.

(4) No-shows
A "No-Show" is someone who misses an appointment without notice. No-Shows inconvenience
patients that are in need of our services. If you fail to be present for your scheduled appointment you will be charged a "No-Show" fee of $25.00. All fees will be due prior to any future visits. Two or more No-Shows may result in the termination of care with Milan Eye Center.

(5) Tardiness
A grace period of 15 minutes will be permitted for unforeseen delays a patient may encounter while traveling to the clinic location for their appointment. If a patient arrives more than 15 minutes late for their appointment, the patient will be given the option of either being seen that day as a walk-in (schedule permitting), or rescheduled for a later date. This process will ensure that patients who arrive on time are seen in a timely manner.

By signing below, you acknowledge that you have read and understand the above New Patient Consent. This consent and authorization does not expire unless/until canceled in writing by me at any time.

_____ _____

Signature of Patient/Authorized Representative *Date*

_____ _____

Name of Authorized Representative *Relationship to Patient*