BALIN EYE & LASER CENTER

PATIENT INFORMATION

Name _____ **Pronouns** _____
Last First M.I. (he/him, she/her, they/them, etc.)

Address _____

City _____ **State** _____ **Zip** _____

Primary Phone _____ ☐ Cell **Second Phone:** _____ ☐ Cell
May we text you with appointment reminders? ☐ Yes ☐ No

Birth Date _____ **Email address** _____
☐ Or check here if denying permission to contact via email

Primary Care Dr. _____ # ( ) _____
Name City

Pharmacy _____ # ( ) _____
Name Address / City

Emergency Contact _____ # ( ) _____
Name Relationship

Employer _____ Occupation _____

Employer Address _____ Work # ( ) _____

How did you hear about us? (Circle one and then specify)

*Family/Friend (name) _____ *Doctor (name) _____ *Internet *Insurance List
*Newspaper (Adovacte / Gazette / Republican) *Radio (WAQY 102.1 / WEEI 105.5 / WHLL 98.1 / WMAS 94.7)
*Seminar / Health Fair *Other (specify) _____

Please present all insurance cards at check-in

Primary Insurance (Company) _____ ID # _____

Policy Holder Name _____ DOB _____ Relationship _____ SS# _____

Secondary Insurance (Company) _____ ID # _____

Policy Holder Name _____ DOB _____ Relationship _____ SS# _____

I understand the Dr. Balin and/or staff routinely take photographs of eyelids, eyes and lesions that are biopsied, excised, or observed. These photographs are used as an integral part of the medical record. Permission is given to use these photographs in speaking to medical or lay audiences and publication in medical journals or the lay press. I also give permission to Dr. Balin and/or staff to send copies of my medical records to any other doctors involved in my care.

ASSIGNMENT OF BENEFITS: I hereby assign all medical and/or surgical benefits available from medical insurance and/or Medicare to Nancy A. Balin, M.D., F.A.C.S This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges wither or not paid by said insurance. I hereby authorize said assignee to release all information necessary to HCFA and/or other insurance agency to secure payment.

Signed _____ **Date** _____

Witness _____ Date _____

Patient Name _____ Birth Date: _____

Please note: You may be asked to update this page yearly Today's Date _____

What brings you here today? _____

For Women: Are you pregnant ?: _____ Yes _____ No Are you breastfeeding ?: ____ Yes ____ No

Health History	For example:	Yes	No	Specific problem
Constitutional	(weight loss, fever, fatigue)	☐	☐	_____
Ear, Nose, Throat	(sinus, allergies, vertigo)	☐	☐	_____
Cardiovascular	(blood pressure, cholesterol, stroke)	☐	☐	_____
Respiratory	(COPD, sleep apnea, asthma)	☐	☐	_____
Gastrointestinal	(acid reflux, ulcers)	☐	☐	_____
Musculoskeletal	(arthritis, muscle/joint pain)	☐	☐	_____
Genitourinary	(prostate, bladder)	☐	☐	_____
Skin	(rosacea, rash, breast problems)	☐	☐	_____
Neurological	(headaches, migraines, seizures)	☐	☐	_____
Psychiatric	(depression, anxiety, schizophrenia)	☐	☐	_____
Endocrine	(diabetes, thyroid, hormone)	☐	☐	_____
Hematologic/Blood	(anemia, clotting, hemorrhaging)	☐	☐	_____
Allergy/Immune	(autoimmune, rheumatoid, HIV)	☐	☐	_____
Other	(cancer, hepatitis, syphilis)	☐	☐	_____

Family History	Y	N	Who		Y	N	Who
Blindness	☐	☐	_____	Cancer	☐	☐	_____
Amblyopia (lazy eye)	☐	☐	_____	Diabetes	☐	☐	_____
Retinal detachment	☐	☐	_____	Heart disease	☐	☐	_____
Macular degeneration	☐	☐	_____	Autoimmune disease	☐	☐	_____
Glaucoma	☐	☐	_____	Hereditary disease	☐	☐	_____
Keratoconus	☐	☐	_____				

Eye History	Y	N	**Eye Symptoms**	Y	N
Blindness	☐	☐	Blurred vision	☐	☐
Amblyopia (lazy eye)	☐	☐	Flashes	☐	☐
Retinal detachment	☐	☐	Floaters	☐	☐
Macular degeneration	☐	☐	Double vision	☐	☐
Cataracts	☐	☐	Eye pain	☐	☐
Keratoconus	☐	☐	Dryness	☐	☐
Patching	☐	☐	Itching	☐	☐
Drooping eyelid	☐	☐	Burning	☐	☐
Eye injury	☐	☐	Watering	☐	☐
Eye infection	☐	☐	Discharge	☐	☐
Styes	☐	☐	Peripheral vision loss	☐	☐
Other _____	☐	☐	Glare/halos	☐	☐
			Other _____	☐	☐

Surgeries including eye surgeries (type and date) _____

Social History (circle day/week)

Alcohol use ☐ Y ☐ N _____drinks/day/week Tobacco use ☐ Y ☐ N _____packs/day

Are you a Fall Risk ?: ☐ Y ☐ N Recreational drugs ☐ Y ☐ N _____

Last eye exam _____ **By** _____

BALIN EYE & LASER CENTER

Today's Date _____

Please note: You may be asked to update this page yearly

Patient Name _____ Birth Date

Have you been vaccinated for pneumonia (if over 65 years old)? ____ Yes _____ No
Have you been vaccinated for Herpes Zoster (if over 65 years old? ____ Yes _____ No

MEDICATIONS (prescription and over-the-counter medications, including eye drops): Name

	Dose	Times per day	Date started

ALLERGIES TO MEDICATION: What is the reaction?

_____

_____

_____

_____

Are you allergic to latex? YES / NO

BALIN EYE & LASER CENTER

Balin Eye & Laser Center
Patient Consent For Use and Disclosure
Of Protected Health Information

I hereby give my consent for Balin Eye & Laser Center to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO), (Balin Eye & Laser Center's Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Balin Eye & Laser Center reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy practices may be obtained by forwarding a written request to Balin Eye & Laser Center, at 269 Locust Street, Northampton, MA. 01062

With this consent, Balin Eye & Laser Center may call my home or alternative location and leave a message on voice mail or in person in reference to any items that assist the practice of carrying about TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Balin Eye & Laser Center may mail to my home or alternative location any item that assists the practice in carrying out TPO, such as reminder appointment cards and patient statements if they are marked Personal and Confidential.

With this consent, Balin Eye & Laser Center may E-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Balin Eye & Laser Center restrict how it uses or discloses my PHI to carry to TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Balin Eye & Laser Center's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Balin Eye & Laser Center may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____
Date signed

_____

Print Name of Patient or Legal Guardian

BALIN EYE & LASER CENTER

Healthcare Eligibility Waiver and Financial Responsibility

Patient Name: _____D.O.B. _____

The patient or patient's legal representative hereby certifies that he/she is eligible for health plan benefits coverage and has chosen Balin Eye and Laser Center as the provider for his/her/their healthcare.

The patient or patient's legal representative understands that he/she/they are responsible for any co-pay and/or deductible. If the patient is found ineligible for coverage of plan benefits, he/she/they are financially responsible for all costs and expenses incurred during the delivery of health services and agrees to pay these charges to the physician accordingly.

If your insurance requires a referral for your appointment with Nancy Balin, M.D., or Kayla Knotts, O.D., please contact your Primary Care Physician to obtain a referral. Please make sure the referral is completed with the correct provider's name with a start date on or before the date of your appointment. If your claim is denied because there is no referral, you will be responsible for the entire charge of your visit.

If you do not cancel a scheduled appointment within 24 hours or the same day, you will be charged a $45.00 fee, which is not covered by your insurance company.

Any questions please contact the office at (413)584-6666. Thank you.

_____Initials by Office Staff

*****Please notice that there is going to be a $15.00 fee for any returned check.**

_____
Signature of Patient or Legal Guardian

_____
Date signed

_____
Print Name of Patient or Legal Guardian

Rev. 8/17/2024