Magnante eye care
A UNITY HEALTHCARE PARTNER

David O. Magnante, M.D.
975 Mezzanine Drive, Suite B
Lafayette, IN 47905
PH: 765449.7564
FX: 765.807.7943

PATIENT'S INFORMATION

Patient's Social Security# _____ - _____ - _____ Date_____

Name_____
Last First Middle Initial

Home Address_____
Street Apt. City/State Zip Code

Home E-mail Address _____

Home Phone _____Mobile Phone _____

Date of Birth _____Marital Status _____ Sex: ☐M ☐F

Race: ☐White ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ Other_____

Language, if not English_____ Ethnicity ☐Hispanic or Latino ☐Not Hispanic or Latino

EMERGENCY CONTACT and MISCELLANEOUS INFORMATION

Emergency Contact Name _____ Relationship _____

Emergency Contact Phone # _____

EMPLOYER INFORMATION

(check) ☐ Full time ☐Part time ☐ Retired ☐Not Employed ☐Self-employed ☐Active Military Duty

Employer_____ Position_____

Employer's phone_____
Employer's Address_____
Street/Office # City/State Zip code

PRIMARY CARE PHYSICIAN

Physician Name:_____Phone Number:_____

REFERRAL INFORMATION

How were you referred to us (check): ☐Employer ☐Family member ☐Friend ☐Website ☐Radio

☐TV ☐ Newspaper ☐Athletic Trainer ☐Emergency Room ☐ Physician Other_____

If physician or trainer referral, please list_____

Pharmacy:_____

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PARENT INFORMATION
(if minor child)

Father's Name _____DOB:_____
Last First MI

Father's Address _____
Street Apt. City/State Zip Code

Father's Phone (home) _____Father's Phone (work) _____
Father's Employer _____SSN:_____
Father's Employer Address _____
Street City/State Zip Code

Mother's Name _____DOB:_____
Last First MI

Mother's Address _____
Street Apt. City/State Zip Code

Mother's Phone (home)_____Mother's Phone (work) _____
Mother's Employer _____SSN:_____
Mother's Employer Address _____
Street City/State Zip Code

INSURANCE INFORMATION

Primary Insurance co. _____

Subscriber's Name _____ Relationship _____
Subscriber's Address _____
Street Apt. City/State Zip Code

Employer _____ Subscriber's DOB _____ Subscriber's SS# _____

Secondary Insurance co. _____

Subscriber's Name _____ Relationship _____
Subscriber's Address _____
Street Apt. City/State Zip Code

Employer _____ Subscriber's DOB _____ Subscriber's SS# _____

Third Insurance co. _____

Subscriber's Name _____ Relationship _____
Subscriber's Address _____
Street Apt. City/State Zip Code

Employer _____ Subscriber's DOB _____ Subscriber's SS# _____

Patient Signature_____Date_____

Parent/Guardian Signature_____Date_____
(if patient is minor child)

UNITY HEALTHCARE, LLC
DISCLOSURE AND RELEASE AUTHORIZATION FORM

CONSENT TO TREAT: I request and give consent to my physician to provide and perform such medical/surgical care, tests, procedures, drugs and other services and supplies as my physician, in his/her professional judgment, deems necessary or beneficial. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me.

_____
Intl

RELEASE OF MEDICAL INFO AND AUTHORIZATION TO PAY INSURANCE BENEFITS: I authorize Unity and my physician to release information from my medical records to my insurance carrier(s), governmental agency, or my employer in the case of work-related injuries, for the purpose of processing claims for medical/workers compensation benefits and state on such claims that my signature is on file. I request that my insurance company(s) honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to my physician, on my behalf.

_____
Intl

FINANCIAL AGREEMENT: I understand all accounts are the full responsibility of the patient and/or the patient's responsible party guarantor. My physician will assist patients in obtaining insurance benefits when those benefits are assigned to my physician. It is the patient's responsibility to make sure insurance payments are processed and paid promptly to my physician. In the case of default payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account of future outstanding accounts. I agree that reasonable attorney fees shall be interpreted as 40% of any balance due at the time the account is sent to an attorney or collection agency for collection, or $200.00, whichever is greater.

_____
Intl

MEDICARE CERTIFICATION: I certify that the information given by me, or by Unity on my behalf, in applying for payment under Title XVIII of the Social Security Act is correct. I authorize my treating physician to release information from my medical record to the Social Security Administration and/or Medicare program or its intermediaries or carriers, or the Professional Standards Review Organizations for the purpose of processing of claims for medical benefits and state on such claims that my signature is on file. I request that payment of such authorized benefits be made directly to my treating physician on my behalf.

_____
Intl

TELEPHONE CONTACTS: I authorize Unity Healthcare, LLC and its affiliates and agents to contact me at the phone numbers I have provided (whether such is my cell phone or land line), including providing me with automated appointment reminders and other automated calls related to the services provided to me.

_____
Intl

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES: I have received the Practice's Notice of Privacy Practices and understand that my protected health information maybe used by the Practice as described in the notice.

_____
Intl

Patient Name/Signature: _____ Date:_____
Parent/Guardian Signature: _____ Date:_____

UNITY HEALTHCARE, LLC
HIPAA AUTHORIZATION DISCLOSURES TO FAMILY AND/OR FRIENDS

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

By signing below, I hereby authorize the following health information to be used and disclosed as described in this Authorization ("Protected Health Information"). _____ **Intl**

The specific person or class of persons who are authorized to use or disclose my Protected Health Information are as follows: Unity Healthcare, LLC _____Division, plus all my other Unity Healthcare providers and professionals ("Unity"). _____ **Intl**

The persons or class of persons to whom Unity, a Covered Entity, may make the use or disclosure of my Protected Health Information are as follows: _____; _____; _____. _____ **Intl**

I understand that the purpose of the use or disclosure is: at my request, to enable them to be aware of and participate in of my care and treatment provided by Unity. _____ **Intl**

I understand that Unity will not condition treatment, payment, and enrollment in a health plan or eligibility for benefits on the provision of this Authorization to Unity. _____ **Intl**

I understand that the information to be disclosed may contain information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), behavioral or mental health services, hepatitis, tuberculosis, and treatment for alcohol and drug abuse. _____ **Intl**
☐ No, I do not authorize this type of disclosure.

This Authorization shall expire: one (1) year from the date signed below. _____ **Intl**

I understand that I have the right to revoke this Authorization by contacting Unity, if the revocation is in writing, except to the extent that Unity has taken action in reliance upon this Authorization. _____ **Intl**

I understand that my Protected Health Information that is used or disclosed under this Authorization may be subject to re-disclosure by the recipient, and the privacy of my Protected Health Information may no longer be protected by the law. _____ **Intl**

I understand that the use or disclosure of my Protected Health Information by Unity will not result in direct or indirect remuneration to Unity from a third party. _____ **Intl**

By signing this Authorization, I acknowledge that I have read and understand this Authorization. Further, I authorize the use or disclosure of my Protected Health Information in accordance with the terms of this Authorization.

Patient Signature:_____Date:_____

FAMILY HISTORY FORM

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Primary Care Physician:_____
Cardiologist:_____
Optometrist: _____
Name of Pharmacy: _____
Name of Physician or person who referred you to our office:_____

Family History (Among Blood Relatives)	YES	NO	F	M	Bro	Sis	MGM	MGP	PGM	PGF
Arthritis										
Blindness										
Cancer										
Cataract										
Diabetes										
Glaucoma										
Heart Disease										
High Blood Pressure										
Kidney Disease										
Lazy Eye										
Macular Degeneration										
Retinal Disease										
Stroke										
Tuberculosis										

NOTES: F=father, M=Mother, Bro=Brother Sis=Sister, MGM=Maternal Gma MGP=MaternalGpa PGM=Paternal Gma, PGF Paternal Gpa

SOCIAL HISTORY

1. Do you smoke? □ Yes □ No
2. If yes, how many cigarettes per day?_____
3. Do you drink alcohol? □ Yes □ No How many drinks per day _____
4. Work Status: □ Working □ Retired
5. Living arrangements: □ Home □ Apartment □ Nursing home □ Other_____
6. Do you drive during the day? □ Yes □ No With difficulty? □ Yes □ No
7. Do you drive at night? □ Yes □ No With difficulty? □ Yes □ No

Please List all DRUG allergies:

_____

_____

Please list all medicines including supplements: _____

_____

_____

_____

Please list past surgeries especially heart surgeries :

_____

Patient Signature: _____Date:_____

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Patient Name:_____Date of Birth:_____

EYES

Previous Surgery	□ Y	□ N
Lasik	□ Y	□ N
Contact Lens	□ Y	□ N
RK	□ Y	□ N
Pain	□ Y	□ N
Double Vision	□ Y	□ N
Glaucoma	□ Y	□ N
Cataracts	□ Y	□ N
Mac Degen	□ Y	□ N
Dry Eye	□ Y	□ N
Flashes / Floaters	□ Y	□ N

EAR, NOSE, THROAT

Hard of Hearing	□ Y	□ N
Ringing in Ears	□ Y	□ N
Vertigo	□ Y	□ N
Difficulty Swallowing	□ Y	□ N

CARDIOVASCULAR

Chest Pain	□ Y	□ N
Dizziness	□ Y	□ N
Fainting Spells	□ Y	□ N
Shortness of Breath	□ Y	□ N
Irregular Heart Beat	□ Y	□ N
Difficulty Lying Flat	□ Y	□ N
Pacemaker / Defib	□ Y	□ N

CONSTITUTIONAL

Fatigue / Weakness	□ Y	□ N
Fever	□ Y	□ N
Weight Loss / Gain	□ Y	□ N

RESPIRATORY

Cough	□ Y	□ N
Congestion	□ Y	□ N
Wheezing	□ Y	□ N
Asthma	□ Y	□ N

GASTROINTESTINAL

Heartburn	□ Y	□ N
Nausea / Vomiting	□ Y	□ N
Jaundice	□ Y	□ N

GENITOURINARY

Pain / Difficulty	□ Y	□ N
Blood in Urine	□ Y	□ N
Kidney Stone Past	□ Y	□ N
History STD	□ Y	□ N

PSYCHIATRIC

Anxiety / Depression	□ Y	□ N
Mood Swings	□ Y	□ N
Difficulty Sleeping	□ Y	□ N

ENDOCRINE

Increased Thirst	□ Y	□ N
Increased Hunger	□ Y	□ N
Increased Urination	□ Y	□ N
Increased Sweating	□ Y	□ N
Fingernail Changes	□ Y	□ N

BLOOD / LYMPNODES

Easy Bruising	□ Y	□ N
Gums Bleed Easily	□ Y	□ N
Prolonged Bleeding	□ Y	□ N
Heavy ASA Use	□ Y	□ N

MUSCOSKELETAL

Stiffness	□ Y	□ N
Arthritis	□ Y	□ N
Joint Pain / Swelling	□ Y	□ N

SKIN

Rash / Sores	□ Y	□ N
Lesions	□ Y	□ N
Hives / Eczema	□ Y	□ N
Skin Cancer	□ Y	□ N

NEUROLOGICAL

Seizures	□ Y	□ N
Weakness / Paralysis	□ Y	□ N
Numbness	□ Y	□ N
Tremors	□ Y	□ N

IMMUNOLOGIC

Hives	□ Y	□ N
Itching	□ Y	□ N
Runny Nose	□ Y	□ N
Sinus Pressure	□ Y	□ N

Unity Healthcare

Acknowledgement of Receipt of Notice of Privacy Practices

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Patient Name: _____

Patient Signature: _____ Date: _____