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Medical Director

*Vision designed for you*

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## WELCOME!

We are thrilled that you have chosen Chesapeake Eye Care & Laser Center to provide your vision care needs. Our carefully selected team of doctors offers exceptional personalized service and knowledge of the latest advancements in eye care. We strive daily to provide you with the best education, highest quality eye care and greatest customer experience. At Chesapeake Eye Care & Laser Center, we provide comprehensive vision care to meet each individual's needs.

In preparation for your appointment, **please bring the following with you:**

- A completed enclosed Medical History Form (Front & Back sides)
- Insurance Card
- Primary Care Physician Referral (if your insurance requires one)

## REGARDING REFERRALS:

If you are unsure if your insurance requires a referral, contact your insurance company and they will give you the necessary requirements. When you speak with your insurance company, be sure to tell them if you are coming for a routine eye exam or if you have a medical condition, such as diabetes, cataracts, glaucoma, infection, injury, etc. Referrals are the patient's responsibility.

## CO-PAYMENTS:

Most insurance companies require patients to pay a co-payment for their visit. Please be prepared to pay this at your visit. We accept cash, personal checks, Visa, MasterCard, and American Express.

## LOCATIONS:

**ANNAPOLIS OFFICE:** Sajak Pavilion, 2002 Medical Parkway, Suite 320, Annapolis, MD

**EDGEWATER OFFICE:** 137 Mitchells Chance Road, Suite 300, Edgewater, MD

We have enclosed a map and directions for your convenience.

If you have any questions, please do not hesitate to call us at 410-571-8733. Thank you again for choosing Chesapeake Eye Care & Laser Center. We look forward to serving you and your eye care needs.

Warm Regards,

*Chesapeake Eye Care & Laser Center*

Enclosures

# MEDICAL HISTORY

FIRST NAME \_\_\_\_\_ M.I. \_\_\_\_\_ LAST NAME \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_  
HOME PH \_\_\_\_\_ WORK PH \_\_\_\_\_ EXT \_\_\_\_\_  
CELL PH \_\_\_\_\_ EMAIL \_\_\_\_\_  
SS# \_\_\_\_\_ D.O.B. \_\_\_\_\_ AGE \_\_\_\_\_ SEX \_\_\_\_\_  
EMERGENCY CONTACT \_\_\_\_\_ PHONE \_\_\_\_\_

Are you interested in learning more about decreasing your dependence on glasses/contacts?  
 YES  NO

Which of the following referred you to Chesapeake Eye Care: (Please be specific. List all sources.)

Friend/Relative/Patient	Newspaper _____	Seminar
Names _____	Mailing _____	_____
_____	Internet/Website _____	Other _____
Physician _____	Event _____	_____
_____	Article _____	_____

## PRIMARY INSURANCE INFORMATION

PRIMARY INSURANCE \_\_\_\_\_  
INSURED NAME \_\_\_\_\_ INSURED'S D.O.B. \_\_\_\_\_  
POLICY NUMBER \_\_\_\_\_ GROUP NUMBER \_\_\_\_\_  
CO-PAY AMOUNTS \_\_\_\_\_

## SECONDARY INSURANCE INFORMATION

SECONDARY INSURANCE \_\_\_\_\_  
INSURED NAME \_\_\_\_\_ INSURED'S D.O.B. \_\_\_\_\_  
POLICY NUMBER \_\_\_\_\_ GROUP NUMBER \_\_\_\_\_

## PATIENT AUTHORIZATION

I authorize Chesapeake Eye Care to apply for benefits on my behalf for services rendered. I request payment from my insurance company to be made directly to the physician. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claims. I permit a copy of this authorization to be used in place of the original. I may revoke this authorization at any time in writing. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical service provided, when a statement is rendered. I understand I will be responsible for any collection fees if my account is delinquent and referred to an attorney for collection purposes. Attorney's fees of 15% will be charged in addition to principal balance of the account if referred to an attorney for collection purposes. Delinquent accounts accrue interest at the rate of 1 1/2% per month.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

Patient Name \_\_\_\_\_

Occupation or hobby \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

Computer Use  Never  Occasional  Daily

When was your last eye exam? \_\_\_\_\_

Do you wear glasses?  Yes  No

By whom? \_\_\_\_\_

Do you wear contact lenses?  Yes  No

### PAST MEDICAL HISTORY

1. Have you ever been treated for any medical condition? (e.g. diabetes, high blood pressure, heart attack, stroke)  Yes  No If yes, explain: \_\_\_\_\_

2. Have you ever had any eye disease? (e.g. glaucoma, macular degeneration, eye turning in or out)  Yes  No If yes, explain: \_\_\_\_\_

3. Have you ever had any surgeries?  Yes  No If yes, explain: \_\_\_\_\_

4. Do you take any medications? (Please include any vitamins and aspirin.)  Yes  No If yes, explain: \_\_\_\_\_

5. Medication Allergies: \_\_\_\_\_

### REVIEW OF SYSTEMS

Do you currently have any problems with the following:

Chronic fever, unexpected weight loss or gain, fatigue

Yes

No

Ear/nose/throat (e.g. hearing loss, sore throat, sinus)

Yes

No

Heart (e.g. chest pain, irregular heart beat)

Yes

No

Respiratory (e.g. shortness of breath, coughing)

Yes

No

Gastrointestinal (e.g. heartburn, diarrhea, vomiting, stomach pain)

Yes

No

Urinary (e.g. pain or discomfort, blood in urine)

Yes

No

Skin conditions (e.g. rash, excessive dryness)

Yes

No

Musculoskeletal (e.g. swollen joints, joint pain)

Yes

No

Neurological (e.g. numbness, weakness, headache, paralysis)

Yes

No

Psychiatric (e.g. depression, anxiety)

Yes

No

Endocrine (e.g. diabetes, thyroid)

Yes

No

Blood Lymph (e.g. high cholesterol, anemia)

Yes

No

### FAMILY AND SOCIAL HISTORY

Do any eye or medical diseases run in your family? (e.g. diabetes, high blood pressure, cancer, glaucoma, macular degeneration)  Yes  No If yes, explain: \_\_\_\_\_

Do you smoke?  Yes  No

Do you drink alcohol?  Yes  No

### PLEASE CIRCLE REASON FOR YOUR VISIT TODAY:

Routine

Surgery

Glasses/Contact Lenses

Medical Problem

Patient/Parent Signature: \_\_\_\_\_

Reviewed By: \_\_\_\_\_ Date: \_\_\_\_\_  No Changes  Updated \_\_\_\_\_

*Chesapeake Eye Care & Laser Center*  
137 Mitchells Chance Road, Suite 300  
Edgewater, MD 21037  
410.956.6400

## DIRECTIONS TO EDGEWATER OFFICE

*Office is located in building called: Main Street Offices, South River Colony.*

### FROM ROUTE 50 WEST:

- Take Exit 23A, bear left onto MD Route 2 South (Solomons Island Road) toward MD-450.
- Follow Route 2 South and cross over the South River Bridge. Go to your sixth (6) traffic light and turn left onto Mitchells Chance Road.
- After you pass McDonalds (on your right), make your third right into the shopping center for Main Street, South River Colony. There will be a big archway with the name "Main Street, South River Colony" on it.
- Proceed to your second stop sign and turn left. The Main Street Offices, South River Colony building is directly in front of you. This is where our office is located.
- Free parking is available in front of the building. Our office is located on the 3rd floor.

### FROM ROUTE 50 EAST:

- Take exit 22 (Route 665 Aris T. Allen Blvd) and follow toward signs for Solomons Island Road/Route 2.
- Exit at Route 2. Bear Right onto Route 2 south.
- Follow Route 2 South and cross over the South River Bridge. Go to your sixth (6) traffic light and turn left onto Mitchells Chance Road.
- After you pass McDonalds (on your right), make your third right into the shopping center for Main Street, South River Colony. There will be a big archway with the name "Main Street, South River Colony" on it.
- Proceed to your second stop sign and turn left. The Main Street Offices, South River Colony building is directly in front of you. This is where our office is located.
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### FROM THE SOUTH:

- Follow Route 2/Solomons Island Road heading North.
- Cross over Route 214/Central Avenue.
- Turn right at the next light onto Mitchells Chance Road.
- After you pass McDonalds (on your right), make your third right into the shopping center for Main Street, South River Colony. There will be a big archway with the name "Main Street, South River Colony" on it.
- Proceed to your second stop sign and turn left. The Main Street Offices, South River Colony building is directly in front of you. This is where our office is located.
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Chesapeake Eye Care & Laser Center  
Sajak Pavilion  
2002 Medical Parkway, Suite 320  
410.571.8733

## DIRECTIONS TO ANNAPOLIS OFFICE

*Our office is located in the Sajak Pavilion.*

### FROM THE EAST:

- Take Route 50 West to Exit 23A and follow signs to the right for Jennifer Road.
- Get in left turn lane. Turn left at light onto Jennifer Road.
- Turn right onto Medical Parkway.
- Turn left at the next traffic light into the parking garage entrance. \*

### FROM THE WEST:

- Take Route 50 East to Exit 23 for Parole/Route 450.
- Bear right onto West Street and stay in right lane.
- Make a right at the first traffic light onto Jennifer Road.
- Make a left at the fourth traffic light onto Medical Parkway.
- Turn left at the next traffic light into the parking garage entrance. \*

### FROM THE SOUTH:

- Take Route 2 North.
- Cross across West Street and Route 2 will connect directly to Medical Parkway.
- Go straight through the light on Jennifer Rd.
- Turn left at the next traffic light into the parking garage entrance. \*

### FROM THE NORTH:

- Take I-97 to Route 50 East to Exit 23 for Parole.
  - Bear right onto West Street and stay in right lane.
  - Make a right at the first traffic light onto Jennifer Road.
  - Make a left at the fourth traffic light onto Medical Parkway.
  - Turn left at the next traffic light into the parking garage entrance. \*
- Once in parking garage, park on the 3rd floor and enter through the 3rd floor garage/building access doors.  
Our office is straight ahead. Parking is free.

