AV EYE CARE REGISTRATION AND HISTORY

PATIENT INFORMATION

Date _____

Patient _____

Address _____

City _____ State _____ Zip _____

Sex: M ☐ F ☐ Age _____ Birthdate _____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient SS# _____

Occupation _____

Employer _____

Employer Address _____

Driver License # _____

Spouse's Name _____

Birthdate _____ SS# _____

Occupation _____

Spouse's Employer _____

Whom may we thank for referring you? _____

_____

INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. OPATOWSKY all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Responsible Party Signature

_____ _____

Relationship Date

PHONE NUMBERS

Home _____ Work _____ Cell _____ Spouse's Work _____

Best time and place to reach you _____ Email address _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone _____ Work Phone _____ Cell: _____

EYE HEALTH HISTORY

Date of last eye exam _____

Name of eye doctor _____

Do you wear glasses? ☐ Yes ☐ No

☐ All the time ☐ Occasionally

☐ Reading ☐ Driving ☐ TV

Do you wear contacts? ☐ Yes ☐ No

Type _____ Hours/Day _____

Describe any problems you have with your eyes

_____

_____

_____

_____

Place a mark on "Yes" or "No" to indicate if you have had any of the following.

Bloodshot Eyes	☐ Yes	☐ No	Floaters or Spots	☐ Yes	☐ No
Blurred Vision - Distance	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No
Blurred Vision - Near	☐ Yes	☐ No	Headaches	☐ Yes	☐ No
Burning Eyes	☐ Yes	☐ No	Itching Eyes	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No	Light Sensitive	☐ Yes	☐ No
Poor Color Vision	☐ Yes	☐ No	Loss of Vision	☐ Yes	☐ No
Crossed Eyes	☐ Yes	☐ No	Macular Degeneration	☐ Yes	☐ No
Discharge from Eyes	☐ Yes	☐ No	Poor Night Vision	☐ Yes	☐ No
Dizzy Spells	☐ Yes	☐ No	Red Eyes	☐ Yes	☐ No
Double Vision	☐ Yes	☐ No	Seeing Halos	☐ Yes	☐ No
Dry Eyes	☐ Yes	☐ No	Seeing Flashes	☐ Yes	☐ No
Eye Infection	☐ Yes	☐ No	Temporary Loss of Vision	☐ Yes	☐ No
Eye Injury	☐ Yes	☐ No	Twitching Eyelids	☐ Yes	☐ No
Eye Strain	☐ Yes	☐ No	Watering Eyes	☐ Yes	☐ No
Fainting Spells, Blackouts	☐ Yes	☐ No			

HEALTH HISTORY

Primary Care
Physician's Name _____ Date of last visit _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following. Also place a mark to indicate if a blood relative has had any of the following problems.

	Yourself		Family Members	
AIDS/HIV	☐ Yes	☐ No	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	☐ Yes	☐ No
Artificial Heart Valve	☐ Yes	☐ No	☐ Yes	☐ No
Artificial Joints	☐ Yes	☐ No	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	☐ Yes	☐ No
Bleeding	☐ Yes	☐ No	☐ Yes	☐ No
Blindness	☐ Yes	☐ No	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No	☐ Yes	☐ No
Chemical Dependency	☐ Yes	☐ No	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No	☐ Yes	☐ No
Eye Surgery	☐ Yes	☐ No	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	☐ Yes	☐ No
Hay Fever	☐ Yes	☐ No	☐ Yes	☐ No
Heart Condition	☐ Yes	☐ No	☐ Yes	☐ No

	Yourself		Family Members	
Hepatitis (Type_____)	☐ Yes	☐ No	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No	☐ Yes	☐ No
Lazy /Crossed Eye	☐ Yes	☐ No	☐ Yes	☐ No
Lupus	☐ Yes	☐ No	☐ Yes	☐ No
Migraine Headaches	☐ Yes	☐ No	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No	☐ Yes	☐ No
Retinal Disease	☐ Yes	☐ No	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No	☐ Yes	☐ No
Shingles	☐ Yes	☐ No	☐ Yes	☐ No
Skin Conditions	☐ Yes	☐ No	☐ Yes	☐ No
Stroke	☐ Yes	☐ No	☐ Yes	☐ No
Surgeries	☐ Yes	☐ No	☐ Yes	☐ No
Thyroid Conditions	☐ Yes	☐ No	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No	☐ Yes	☐ No

Are you pregnant? _____ Number of Children _____
Tobacco use _____ Alcohol use _____

MEDICATION AND SUPPLEMENTS

List medications you are currently taking, including eye drops:

_____
_____
_____
_____
_____

ALLERGIES

List your allergies to medications or other substances:

_____
_____
_____
_____
_____

REVIEW OF SYSTEMS

Do you currently have any of the following problems:			If Yes, please explain
Chronic fever, unexpected weight loss/gain, fatigue	☐ Yes	☐ No	_____
Ear/nose/throat problems (e.g. hearing loss, sinus problems, sore throat)	☐ Yes	☐ No	_____
Heart problems (e.g. chest pains, irregular heart beat)	☐ Yes	☐ No	_____
Respiratory problems (e.g. shortness of breath, wheezing, coughing)	☐ Yes	☐ No	_____
Gastrointestinal problems (e.g. heartburn, abdominal pain, diarrhea, vomiting)	☐ Yes	☐ No	_____
Urinary problems (e.g. pain or discomfort, blood in urine, prostate)	☐ Yes	☐ No	_____
Skin problems (e.g. rashes, excessive dryness)	☐ Yes	☐ No	_____
Musculoskeletal problems (e.g. muscle aches, joint pain, swollen joints)	☐ Yes	☐ No	_____
Neurologic problems (e.g. numbness, weakness, headaches, paralysis)	☐ Yes	☐ No	_____
Psychiatric problems (e.g. depression, anxiety)	☐ Yes	☐ No	_____

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. OPATOWSKY for any services furnished me by that doctor. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____
Signature of Beneficiary Date