

- Richard A. Burgett, M.D., F.A.C.S.
- Thomas A. Ciulla, M.D.
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- Kevin E. Lai, M.D.
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## PATIENT REGISTRATION



**MIDWEST EYE INSTITUTE**  
ESTABLISHED 1982

- Raj K. Maturi, M.D.
- John T. Minturn, M.D.
- Daniel E. Neely, M.D.
- Hemang C. Patel, M.D.
- David A. Plager, M.D.
- Gavin J. Roberts, M.D.
- Stephen J. Saxe, M.D.
- Milan Shah, M.D.
- Derek T. Sprunger, M.D.
- Robert M. Troyer, M.D.
- Michael G. Welsh, M.D., F.A.C.S.

### PATIENT INFORMATION

Name: \_\_\_\_\_ Date: \_\_\_\_\_  

Last
First
Middle

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender:  M  F Social Security #: \_\_\_\_\_  

mm/dd/yyyy
xxx-xx-xxxx

Address: \_\_\_\_\_ Apt #: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Mobile: (\_\_\_\_) \_\_\_\_\_

Email Address: \_\_\_\_\_

Preferred Method of Phone Contact:  Mobile  Home  Work (please check one)

Marital Status:  Single  Married  Divorced  Widowed  Separated  Minor Child

Spouse's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_  

mm/dd/yyyy
xxx-xx-xxxx

Spouse's Employer: \_\_\_\_\_ Address: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_

Ethnicity:  Hispanic or Latino  Not Hispanic or Latino  Unknown  Decline to answer

Race:  American Indian or Alaska Native  White  
 Asian  Other Race  
 Black or African American  Decline to answer  
 Native Hawaiian or Other Pacific Islander

If patient is a minor, lives with: \_\_\_\_\_ Relationship: \_\_\_\_\_

Student Status:  Full-Time  Part-Time  Not-a-Student

School Name: \_\_\_\_\_ Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

#### PATIENT OR PARENT / LEGAL GUARDIAN

Employment Status:  Full-Time  Part-Time  Retired  Not-Employed

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

### EMERGENCY CONTACT

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address (if different from patient): \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Primary Phone #: (\_\_\_\_\_) \_\_\_\_\_ Alternate Phone #: (\_\_\_\_\_) \_\_\_\_\_

### RESPONSIBLE PARTY: (if other than patient, please complete)

Responsible Party:  Guarantor  Self

Responsible Party Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Last First Middle

Check here if address is same as patient

Address: \_\_\_\_\_ Apt #: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
mm/dd/yyyy xxx-xx-xxxx

Home Phone: (\_\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_\_) \_\_\_\_\_ Mobile: (\_\_\_\_\_) \_\_\_\_\_

Employer Name: \_\_\_\_\_ Address: \_\_\_\_\_

### REFERRING PHYSICIAN & PHARMACY INFORMATION

Name of Referring Physician: \_\_\_\_\_ Phone #: (\_\_\_\_\_) \_\_\_\_\_

Name of Family/Primary Care Physician: \_\_\_\_\_ Phone #: (\_\_\_\_\_) \_\_\_\_\_

Primary Physician Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Preferred Pharmacy Name: \_\_\_\_\_ Phone #: (\_\_\_\_\_) \_\_\_\_\_

Preferred Pharmacy Address: \_\_\_\_\_ Phone #: (\_\_\_\_\_) \_\_\_\_\_

### MEDICAL INSURANCE INFORMATION

Do you have medical insurance to cover your examination or treatment?  Yes  No  
*If Yes, we will take a copy of your insurance card(s). If you do not have your insurance card with you, please provide us with your insurance carrier and your I.D. #:* \_\_\_\_\_

Does your insurance company require a formal authorization or referral from a Primary Care Physician for our services?  
 Yes  No If Yes, Physician's Name: \_\_\_\_\_

### ACCIDENT INFORMATION: (Complete if your treatment is for an injury or accident)

Were you injured at work?  Yes  No Is this covered by Workman's Compensation?  Yes  No

Contact Person at Your Employer: \_\_\_\_\_

Date & Time of Accident: \_\_\_\_\_ Location: \_\_\_\_\_

How did injury happen? \_\_\_\_\_

Name of Physician who treated you at the time of accident: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

## **PATIENT REGISTRATION CONTINUE**

### **RELEASE OF INFORMATION**

I authorize the release of any medical information necessary to my insurance company relative to services rendered. I further authorize the Payment of Benefits to the Physician for services rendered. I understand that this authorization remains valid unless/until I revoke it myself.

X \_\_\_\_\_ Date: \_\_\_\_\_  
Signature of Patient or Legal Guardian

### **FINANCIAL RESPONSIBILITY STATEMENT**

I acknowledge responsibility for payment of all medical fees regardless of insurance I may have to assist me in this responsibility. The only exception will be charges for services covered under a contractual agreement that has been entered into between my physician and an insurance company, or other third party payor. If for any reason my account should become delinquent, I am liable to pay all collection and legal fees.

X \_\_\_\_\_ Date: \_\_\_\_\_  
Signature of Patient or Legal Guardian

### **IMAGING RELEASE**

I consent that images, including photographs, may be taken in connection with the medical services I receive. I understand that such images shall be retained in my medical record and may need to be shared with others, including but not limited to my insurance carrier. I also give permission for these images and information relative to them and/or relating to my case to be published and republished for the purposes of medical research, education or science. I realize any publication of these images will be "de-identified" so they cannot be recognized as belonging to me specifically. I understand that this release remains valid unless/until I revoke it myself.

X \_\_\_\_\_ Date: \_\_\_\_\_  
Signature of Patient or Legal Guardian

*Note: If these consents are signed by a Legal Guardian, your physician reserves the right to request the Power of Attorney (POA), or other legal document, that assign that right.*

# MIDWEST EYE INSTITUTE MEDICAL HISTORY

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

Reason for Referral: \_\_\_\_\_

## MEDICAL HISTORY

High Blood Pressure  High Cholesterol  Heart Disease  Diabetes  Thyroid Disease  History of Cancer  
 Other (please explain): \_\_\_\_\_

Have you had a pneumonia shot within the past 5 years?  Yes  No

Have you had a current flu vaccine?  Yes  No

## SURGICAL HISTORY

Please list all surgeries, including prior eye surgeries, and the date of each

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## SOCIAL HISTORY

*(Please Check the Box)*

**Marital Status:**  Married  Single  Divorced  Widowed  Separated

**Smoking:**  Smoker  Ex- Smoker (Quit Date: \_\_\_\_\_)  Never Smoked

**Alcohol:**  None  Occasional or Social  1-2 Drinks/Day  3-4+ Drinks/Day

**Occupation:** \_\_\_\_\_

**Living Condition:**  Alone or With Spouse  Nursing Home  Family  Caretaker  Other \_\_\_\_\_

**Use of Illegal Drugs:**  Yes  No *If yes, what and how long?* \_\_\_\_\_

**Have you ever had sexual contact with a person who was exposed to or is infected with a sexually transmitted disease?**  Yes  No *If yes, please specify:* \_\_\_\_\_

## MEDICATIONS

List all medications, both prescribe and over the counter, with the dosage and how often the medication is used (including vitamins, supplements, herbs, and eye drops). You may also provide us with a copy of your own list of medications.

NAME	FOR WHAT CONDITION	DOSAGE	HOW OFTEN?

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**ALLERGIES**

Please check below for the type(s) of allergy and explain the type of reaction you experienced:

- Medication: \_\_\_\_\_
- Anesthesia: \_\_\_\_\_  Latex: \_\_\_\_\_  Dye: \_\_\_\_\_
- Other, please explain: \_\_\_\_\_

**FAMILY HISTORY**

Please check below any hereditary condition that an **immediate family member** has been diagnosed with. Also indicate what family member(s) it applies to.

- Macular Degeneration: \_\_\_\_\_
- Glaucoma: \_\_\_\_\_
- Retinal Detachment: \_\_\_\_\_
- Diabetes: \_\_\_\_\_
- Cancer: \_\_\_\_\_
- Retinitis Pigmentosa: \_\_\_\_\_
- Other, please explain: \_\_\_\_\_

**REVIEW OF SYSTEMS**  
Please check if you are currently experiencing or has experienced these symptoms/conditions.

<p><b>Allergy and Immunology:</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Seasonal</li><li><input type="checkbox"/> Autoimmune Disease</li><li><input type="checkbox"/> Other: _____</li></ul> <p><b>Ocular Symptoms and Diseases:</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Loss of Vision <input type="checkbox"/> Distorted Vision <input type="checkbox"/> Double Vision</li><li><input type="checkbox"/> Dryness <input type="checkbox"/> Itching or Burning Sensation <input type="checkbox"/> Eye Pain</li><li><input type="checkbox"/> Eye Injuries <input type="checkbox"/> Corneal Disease <input type="checkbox"/> Glaucoma</li><li><input type="checkbox"/> Lazy or Crossed Eyes <input type="checkbox"/> Macular Degeneration</li><li><input type="checkbox"/> Other: _____</li></ul> <p><b>Cardiovascular:</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Chest Pain <span style="margin-left: 100px;"><input type="checkbox"/> Swelling of Feet</span></li><li><input type="checkbox"/> Shortness of Breath <span style="margin-left: 100px;"><input type="checkbox"/> Irregular Heartbeat</span></li><li><input type="checkbox"/> Other: _____</li></ul> <p><b>Constitutional:</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Fever <input type="checkbox"/> Weight Loss <input type="checkbox"/> Fatigue <input type="checkbox"/> Loss of Appetite</li><li><input type="checkbox"/> Other: _____</li></ul> <p><b>Endocrine:</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Elevated Blood Sugar <input type="checkbox"/> Low Blood Sugar <input type="checkbox"/> Sweating</li><li><input type="checkbox"/> Other: _____</li></ul> <p><b>Gastrointestinal:</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Diarrhea <input type="checkbox"/> Ulcers</li><li><input type="checkbox"/> Other: _____</li></ul> <p><b>Musculoskeletal:</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Muscle Aches <input type="checkbox"/> Joint Pain <input type="checkbox"/> Unable to Lay Flat</li><li><input type="checkbox"/> Other: _____</li></ul>	<p><b>Genitourinary:</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Kidney Stones <input type="checkbox"/> Dialysis</li><li><input type="checkbox"/> Bladder or Prostate Problem</li><li><input type="checkbox"/> Other: _____</li></ul> <p><b>Hematology &amp; Oncology:</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Prolonged Bleeding <input type="checkbox"/> Cancer</li><li><input type="checkbox"/> Other: _____</li></ul> <p><b>Head, Ears, Nose, and Throat:</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Hearing Loss <input type="checkbox"/> Dry Mouth</li><li><input type="checkbox"/> Other: _____</li></ul> <p><b>Respiratory:</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Difficulty Breathing <input type="checkbox"/> Wheezing <input type="checkbox"/> Cough</li></ul> <p><b>OB/GYN:</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Breast Tenderness <input type="checkbox"/> Abnormal Menstruation</li><li><input type="checkbox"/> Other: _____</li></ul> <p><b>Integumentary:</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Change in Mole(s) <input type="checkbox"/> Rash or Bruising</li><li><input type="checkbox"/> Other: _____</li></ul> <p><b>Neurological:</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Headaches <input type="checkbox"/> Dizziness <input type="checkbox"/> Paralysis <input type="checkbox"/> Tremors</li><li><input type="checkbox"/> Other: _____</li></ul> <p><b>Psychiatric:</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Anxiety <input type="checkbox"/> Depression</li><li><input type="checkbox"/> Other: _____</li></ul> <p><b>OTHER, please explain:</b> _____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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M.D. / Tech: \_\_\_\_\_ Date Revisited: \_\_\_\_\_



# MIDWEST EYE INSTITUTE

*Corneal & External Disease*

Robert D. Deitch, M.D.  
Stephen M. Johnson, M.D.

*Glaucoma*

Hemang C. Patel, M.D.  
Robert M. Troyer, M.D.

*Oculoplastic & Orbital Surgery*

Richard A. Burgett, M.D., F.A.C.S.  
Scott R. Hobson, M.D., F.A.C.S.  
Ronald T. Martin, M.D., F.A.C.S.  
Michael G. Welsh, M.D., F.A.C.S.

*Pediatric Ophthalmology  
& Adult Strabismus*

Kathryn M. Haider, M.D.  
Daniel E. Neely, M.D.  
David A. Plager, M.D.  
Gavin J. Roberts, M.D.  
Derek T. Sprunger, M.D.

*Vitreoretinal Disease & Surgery*

Thomas A. Ciulla, M.D.  
Neil P. Finnen, M.D.  
Frank N. Hrisomalos, M.D.  
Nicholas F. Hrisomalos, M.D.  
Raj K. Maturi, M.D.  
John T. Minturn, M.D.  
Stephen J. Saxe, M.D.  
Milan Shah, M.D.

*Neuro Ophthalmology*

Kevin E. Lai, M.D.

*Corporate Officers:*

Robert J. Boeglin, M.D.  
John T. Minturn, M.D.  
Naval Sondhi, M.D.  
Barbara G. Bernhard, COO

*North Office:*

10300 North Illinois Street, Suite 1000  
Indianapolis, Indiana 46290  
Telephone: (800) 822-4699  
Telephone: (317) 817-1000

*South Office:*

Indiana American Office Park  
555 East County Line Road  
Greenwood, Indiana 46143  
www.midwesteye.com

## A Statement to Midwest Eye Institute Patients Regarding Dilation of Your Eyes

We would like to inform our patients that it may be necessary during the course of your exam to **dilate your eyes with drops**. In some people, the dilating drops cause blurred vision, light sensitivity, and inability to read. These problems go away as the effects of the drops wear off. You should be careful walking, going up and down stairs, and should not drive a car. In very rare cases, the drops may cause elevated eye pressure requiring further treatment.

It is for this reason that we recommend someone come with you at the time of your exam as a driver. Also, for your comfort, you may obtain dark glasses or inserts for your glasses at the reception desk.

I certify that I have read and understand the statement regarding dilation and wish to proceed with the eye examination.

Signature of Patient /  
Parent or Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

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## Patient's Medicare Authorization

Note: To be signed only by patients who are covered by Medicare

**Patient Name:** \_\_\_\_\_

**Patient's Medicare Number:** \_\_\_\_\_

I request the payment of appropriate, authorized Medicare benefits be made on my behalf to *my physician/provider (checked above)* for any services furnished to me by this physician/provider. Additionally, I authorize my medical provider to release any information about me to the Health Care Financing Administration, Centers for Medicare/Medicaid, and/or their agents, that might be needed to determine any benefits payable for the services furnished.

I will also permit a copy of this authorization to be used in place of the original.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## Patient's Third Party Payer and/or Medicare Supplement Authorization

I request the payment of appropriate, authorized benefits be made on my behalf to *my physician/provider (checked above)* for any services furnished to me by this physician/provider. Additionally, I authorize my medical provider to release any information about me to the insurance carrier and/or third party medical claims administrator, covering my at the time medical services are provided, that might be needed to determine any benefits payable for the services furnished.

I will also permit a copy of this authorization to be used in place of the original.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



## MIDWEST EYE INSTITUTE

### NOTICE OF PRIVACY PRACTICES

**As our Patient, we are offering you a copy of Midwest Eye Institute's Notice of Privacy Practices to retain for your information/reference.**

**Copies are also available at any time from our reception desk, or directly from the doctor's office. You are welcome to review or have a copy of this notice at anytime upon request.**

### COMPLAINTS/COMMENTS

If you have any comments, questions, or complaints concerning our privacy practices, you may also contact the Secretary of the Department of Health and Human Services at:

Secretary of the Department of Health and Human Services  
200 Independence Avenue  
S.W., Room 509F, HHH building  
Washington, D.C. 20201  
Email: [ocrmail@hhs.gov](mailto:ocrmail@hhs.gov)

**YOU WILL NOT BE RETALIATED AGAINST OR PENALIZED BY US FOR MAKING AN INQUIRY OR FILING A COMPLAINT.**

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To obtain more information concerning this notice, you may contact our Privacy Officer:

**Barbara Bernhard**  
**Executive Director/Chief Operating Officer**  
**Midwest Eye Institute, P.C.**  
**10300 North Illinois Street, Suite 1000**  
**Indianapolis, Indiana 46290**  
**Attn: Patient Privacy Request**

### SIGNATURE REQUIRED

Your signature is required below indicating that the entirety of the Midwest Eye Institute Privacy Practices policy has been shared with you. By signing you also acknowledge that an actual copy of this entire policy has been offered to you. A copy of this signature page will be maintained in your medical chart.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Name – [Printed]

The Notice of Privacy Practices is effective April 1, 2003.





# MIDWEST EYE INSTITUTE

ESTABLISHED 1982

## AUTHORIZATION

### FOR RELEASE/USE/DISCLOSURE OF HEALTH INFORMATION

This form should not be completed unless the patient agrees to a PHI release. If release of the patient's PHI to anyone other than the referring physician is not required, this form is not required.

#### Dear Patient,

This form is OPTIONAL. It is to be used in the event that either the patient, or the treating physician, has a specific desire or need to release all or any portion of a patient's protected health information (a/k/a PHI)/medical record to any persons or organizations not already involved with the patient's care.

*If you do not wish to have any of your medical information shared with anyone other than the physician that referred you to Midwest Eye Institute, YOU DO NOT NEED TO COMPLETE THIS FORM.*

This form is included with a new patient's paperwork in order to provide an opportunity for a patient to provide authorization for the Midwest Eye treating physician to share their PHI to a guardian; other family members; non-referring physician(s); and/or other parties.

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Name of your Midwest Eye Physician:** \_\_\_\_\_

#### **Name of Person(s) and/or Organization(s) authorized to receive information:**

[Include anyone you want to have information about the treatment you receive at Midwest Eye]

1. \_\_\_\_\_ Relationship: \_\_\_\_\_
2. \_\_\_\_\_ Relationship: \_\_\_\_\_
3. \_\_\_\_\_ Relationship: \_\_\_\_\_
4. \_\_\_\_\_ Relationship: \_\_\_\_\_

**Limitations** to this Authorization must be identified below. If this portion of the form is left blank, it is assumed that the information authorized for released is unrestricted. Please describe below any restrictions you wish to place on this authorization. [Restrictions might include limitations as to type of information released; specific dates or period of time involved; or a specific purpose for which the release might apply.]

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**As a patient I understand and accept the following statements:**

I may see and copy the information described on this form if I ask for it, and I can receive a copy of this form after I sign it if I request one.

**Patient Initials** \_\_\_\_\_

If my physician has initiated this Authorization, I understand that in most cases I will be treated regardless of whether I sign this authorization. However, if the purpose of the Authorization is to allow research-related treatment, I understand I may not be able to get that treatment without signing this form

**Patient Initials** \_\_\_\_\_

**I hereby authorize the release / use / disclosure of my individually identifiable health information (a/k/a Protected Health Information of PHI) as described above.** I understand that this authorization is voluntary. I also understand that if the person or organization authorized to receive the information is not a health plan, health care provider, or contracted business associate of this practice or Midwest Eye Institute, the released information may no longer be protected by federal privacy regulations.

**Patient Initials** \_\_\_\_\_

**[Note: If the patient is unable to sign for themselves and is underage, or if there is a Medical Power of Attorney in effect, a legal guardian or the POA must sign this release below as "patient representative" If this Authorization has been initiated by anyone other than the patient, their legal guardian or the patient's authorized representative, the patient may refuse to sign this Authorization.]**

Date: \_\_\_\_\_

**SIGNATURE OF PATIENT, LEGAL GUARDIAN, OR PATIENT REPRESENTATIVE**

**PRINTED NAME OF GUARDIAN OR REPRESENTATIVE:** \_\_\_\_\_

**As appropriate, describe guardian's or representative's relationship to patient:** \_\_\_\_\_

**Witness:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*[Witness if required if someone other than the patient is signing on behalf of the patient.]*

**Expiration date (optional):** Patient can set an expiration date for this Authorization in this space.

This authorization will expire on: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (MM/DD/YY) or on the occurrence of the following event:

**REVOCAION (optional):** This authorization may be revoked at any time by notifying your Midwest Eye Physician in writing at:

Dr. \_\_\_\_\_

C/O Midwest Eye Institute  
10300 North Illinois St., Suite 1000  
Indianapolis, IN 46290

*If I, as a patient or patient representative, do revoke this authorization, I understand that action will not apply to activity that occurs before the Revocation is received.*