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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
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White
☐ Other Race
☐ Decline to answer

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?

CONTINUE ON REVERSE

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.

Allergy and Immunology:
☐ Seasonal
☐ Autoimmune Disease
☐ Other: _____

Ocular Symptoms and Diseases:
☐Loss of Vision ☐Distorted Vision ☐Double Vision
☐Dryness ☐Itching or Burning Sensation ☐Eye Pain
☐Eye Injuries ☐Corneal Disease ☐Glaucoma
☐Lazy or Crossed Eyes ☐Macular Degeneration
☐Other: _____

Cardiovascular:
☐Chest Pain ☐Swelling of Feet
☐Shortness of Breath ☐Irregular Heartbeat
☐Other: _____

Constitutional:
☐ Fever ☐ Weight Loss ☐Fatigue ☐Loss of Appetite
☐ Other: _____

Endocrine:
☐Elevated Blood Sugar ☐Low Blood Sugar ☐Sweating
☐Other: _____

Gastrointestinal:
☐Abdominal Pain ☐Diarrhea ☐Ulcers
☐Other: _____

Musculoskeletal:
☐Muscle Aches ☐Joint Pain ☐Unable to Lay Flat
☐Other: _____

Genitourinary:
☐Kidney Stones ☐Dialysis
☐Bladder or Prostate Problem
☐Other: _____

Hematology & Oncology:
☐Prolonged Bleeding ☐Cancer
☐Other: _____

Head, Ears, Nose, and Throat:
☐Hearing Loss ☐Dry Mouth
☐Other: _____

Respiratory:
☐Difficulty Breathing ☐Wheezing ☐Cough

OB/GYN:
☐Breast Tenderness ☐Abnormal Menstruation
☐Other: _____

Integumentary:
☐Change in Mole(s) ☐Rash or Bruising
☐Other: _____

Neurological:
☐Headaches ☐Dizziness ☐Paralysis ☐Tremors
☐Other: _____

Psychiatric:
☐Anxiety ☐Depression
☐Other: _____

OTHER, please explain: _____

M.D. / Tech: _____ _____ Date Revi ed: _____

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: _____

Please send all correspondence to North Office
9/18

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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

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

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.]

_____

_____

_____

[Form continues to reserve side]

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:

_____

_____

REVOCATION (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.