☐ Richard A. Burgett, M.D., F.A.C.S.
☐ Thomas A. Ciulla, M.D.
☐ Robert D. Deitch, M.D.
☐ Neil P. Finnen, M.D.
☐ Kathryn M. Haider, M.D.
☐ Scott R. Hobson, M.D., F.A.C.S.
☐ Frank N. Hrisomalos, M.D.
☐ Nicholas F. Hrisomalos, M.D.
☐ Stephen M. Johnson, M.D.
☐ Kevin E. Lai, M.D.
☐ Ronald T. Martin, M.D., F.A.C.S.

PATIENT REGISTRATION UPDATE

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.
☐ Milan Shah, M.D.
☐ Clark L. Springs, M.D.
☐ Derek T. Sprunger, M.D.
☐ Robert M. Troyer, M.D.
☐ Michael G. Welsh, M.D., F.A.C.S.

Patient Name: _____ **Date:** _____

Date of Birth: _____ (mm/dd/yyyy) Age:_____ Social Security #: _____ (xxx-xx-xxxx)

Current Address: _____Apt #: _____City: _____State: ____ Zip: _____

Employer Name: _____ Occupation: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Work Phone: (_____) _____ Mobile: (_____) _____

Email Address: _____

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

MEDICAL INSURANCE INFORMATION

Primary Insurance Carrier: _____

Secondary Insurance Carrier: _____

We will need to make a copy of your current insurance cards

How is the "Insured" party related: ☐ Self ☐ Guarantor ☐ Spouse

Spouse's Name: _____ Date of Birth: _____ (mm/dd/yyyy) Social Security #: _____ (xxx-xx-xxxx)

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: _____

PRIMARY CARE PHYSICIAN

Have you changed Primary Care Physician? ☐ Yes ☐ No

If Yes, Physician's Name: _____Phone #: (_____) _____

Primary Care Physician's Address:_____ City: _____State: ____ Zip: _____

Preferred Pharmacy Name: _____ Phone #: (_____) _____

Preferred Pharmacy Address: _____ City: _____State: ____ Zip: _____

PATIENT REGISTRATION UPDATE CONTINUED

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

MIDWEST EYE INSTITUTE MEDICAL HISTORY UPDATE

Name _____ Birthdate _____ Date _____

Referring Physician _____

Primary Care Physician, Internist or Endocrinologist _____

Have you been diagnosed with any of the following:

	Yes	No	Date of Onset
High Blood Pressure	☐	☐	_____
Diabetes	☐	☐	_____
Heart Disease	☐	☐	_____
Lung Disease	☐	☐	_____
Stroke	☐	☐	_____
Cancer	☐	☐	_____
Migraine	☐	☐	_____

Please list any other conditions for which you have been under medical care.

_____

_____

List all medications including vitamins & herbal supplements.

Any changes to medications since last visit? ☐ YES ☐ NO

1. _____ 7. _____
2. _____ 8. _____
3. _____ 9. _____
4. _____ 10. _____
5. _____ 11. _____
6. _____ 12. _____

Are you allergic to any medications? ☐ YES ☐ NO

If YES, list medications _____

Are you allergic to latex? ☐ YES ☐ NO

List all surgeries, including eye surgeries, and date of each

Any additional surgeries since last visit? ☐ YES ☐ NO

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Any problems with anesthetics (local or general) ☐ YES ☐ NO

If YES, please describe _____

Have you had a MRI or CT Scan? ☐ YES ☐ NO

If YES, what were the results _____

History Reviewed.

Date _____

M.D. Signature Required _____