PATIENT REGISTRATION

☐ Richard A. Burgett, M.D., F.A.C.S.
☐ David A. Camp, M.D.
☐ Thomas C. Ciulla, M.D.
☐ Neil P. Finnen, M.D.
☐ June Geng, M.D.
☐ Scott R. Hobson, M.D., F.A.C.S.
☐ Frank N. Hrisomalos, M.D.
☐ Nicholas F. Hrisomalos, M.D.

☐ Denis Jusufbegovic, M.D.
☐ Raj K. Maturi, M.D.
☐ John T. Minturn, M.D.
☐ Jennifer M. Nottage, M.D.
☐ Hemang C. Patel, M.D.
☐ Ankur M. Shah, M.D.
☐ Milan Shah, M.D.

MIDWEST EYE INSTITUTE
ESTABLISHED 1982

PATIENT INFORMATION

Name: _____ **Date:** _____
Last First Middle

Date of Birth: _____ Age: _____ Gender: ☐ M ☐ F SS #: _____
mm/dd/yyyy xxx-xx-xxxx

Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____

Home Ph.: (____) _____ Work Ph.: (____) _____ Mobile: (____) _____

Email: _____ ☐ or Text Appointment Notice *(optional)* ☐

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: _____ 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 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

CONSENT FOR BLOOD-BORNE INFECTIOUS DISEASE TESTING

I authorize my physician to test for blood-borne infectious diseases including but not limited to hepatitis, Acquired Immune Deficiency syndrome ("AIDS"), and Human Immunodeficiency Virus ("HIV"), as indicated medically or to protect the health of the care-givers of this organization, as per protocol. The results of these tests will become part of my confidential medical record. Such testing will not be completed unless medically necessary and patient will be advised of the necessity.

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 ☐ Sweat
☐ Other:

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

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

Genitourinary:
☐ Kidney Stones ☐ Dialysis
☐ Bladder/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 Reviewed:

MIDWEST EYE INSTITUTE

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.

Date of Birth: _____

Name Printed: _____

Signature of
Patient / Parent
or Guardian: _____

Date: _____

MIDWEST EYE INSTITUTE

ESTABLISHED 1982

FLUORESCEIN ANGIOGRAPHY RELEASE

I understand the risk, and have been advised of potential adverse physical reactions to Fluorescein Dye. Additionally, I understand that my physician feels the possible risks of severe reactions from Fluorescein Dye are much less than the benefits of better diagnosis and treatment that can result from the procedure. Therefore, I agree to proceed with the Fluorescein Angiogram study.

X _____

Signature of Patient

_____

Patient Name Printed

_____ _____

Witness Date

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☐ Milan Shah, M.D.
☐ Michael G. Welsh, M.D., F.A.C.S.

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 me 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:*** _____

Notice of Privacy Practices

Patient Name-[printed]: _____

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, on our website, or directly from the doctor's office. You are welcome to review, or have a copy of, this notice at any time upon 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:** _____

Authorization for Release/Disclosure of Health Information

This section 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 section is NOT required. By signing this section, you authorize your Midwest Eye provider to disclose your PHI to your immediate family, including but not limited to, your parents, your spouse, and your adult-aged children.** You may see and copy the information described on this form if you ask for it, and you can receive a copy of this form after you sign it, should you request one.

Name of Person(s) and/or Organization(s) OTHER THAN immediate family member or referring physician(s) authorized to receive information:

1. _____ Relationship: _____
2. _____ Relationship: _____

Limitations to this Authorization must be identified below. Such as: If you don't want us to release/disclose your PHI to certain family member(s), please list those individuals below. If this portion of the form is left blank, it is assumed that the information for released is unrestricted.

_____

_____

As a patient I understand and accept the following statements:

- 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.
- 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.

[Note: If the patient is unable to sign for themselves and/or 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.]

Signature of Patient, Legal Guardian, or Patient Representative _____ Date: _____

Printed name of Guardian or Representative: _____ Relationship to Patient: _____

Witness (required if not signed by the patient): _____ Date: _____

Expiration date (optional):_____/_____/_____ (MM/DD/YY) or on the occurrence of the following event:

_____

This authorization may be revoked at any time by notifying your Midwest Eye Physician in Writing