# PATIENT REGISTRATION UPDATE

MIDWEST EYE INSTITUTE
*ESTABLISHED 1982*

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**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: ______________________ ☐ or Text Appointment Notice (optional) ☐

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

## EMERGENCY CONTACT

Name: ______________________________ Relationship to Patient: ____________________

Address (if different from patient): ____________________ City: ______________ State: _____ Zip: ________

Primary Phone: (_______) ____________________ Alternate Phone: (_______) ____________________

## 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

## MEDICARE AUTHORIZATION

I request the payment of appropriate, authorized Medicare benefits be made on my behalf to my physician/provider 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.

**X** ________________________________________ Date: ________________
Signature of Patient or Legal Guardian

☐ NOT APPLICABLE

## 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 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.

**X** ________________________________________ Date: ________________
Signature of Patient or Legal Guardian

☐ NOT APPLICABLE

# 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 |
|---|---|---|---|
| Cholestrol | ☐ | ☐ | __________ |
| High Blood Pressure | ☐ | ☐ | __________ |
| Diabetes | ☐ | ☐ | __________ |
| Heart Disease | ☐ | ☐ | __________ |
| Lung Disease | ☐ | ☐ | __________ |
| Stroke | ☐ | ☐ | __________ |
| Cancer | ☐ | ☐ | __________ |
| Migraine | ☐ | ☐ | __________ |
| Thyroid | ☐ | ☐ | __________ |

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

____________________

____________________

Have you had pneumonia vaccine within the past 5 years? ☐ YES ☐ NO

Have you had a current flu vaccine? ☐ YES ☐ NO

List all medications including eye drops, 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 new surgeries since last visit? ☐ YES ☐ NO

| | |
|---|---|
| 1. __________ | 3. __________ |
| 2. __________ | 4. __________ |

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

If YES, please describe ____________________

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

If YES, what were the results ____________________

History Reviewed.

Date __________

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M.D. Signature Required ____________________