Robert L. Stephenson, M.D.
Robert C. Erickson, M.D.

Timothy P. Page, M. D.
Maria Jancevski, M.D.

PATIENT REGISTRATION FORM

Please Print

Patient Name ____________________________ **Social Security #** ____________________

Address____

City____ **State**_________ **Zip**_____________

Home phone________________________ **Cell phone**______________________________

Email ____

Date of Birth_______/_______/_______ **Sex - M F** **Marital Status – M S W D**

Primary Language __________________ **Patient declines**

Race _____________________________ **Patient declines**

Ethnicity__________________________ **Patient declines**

Employer Name_______________________________ **phone**_________________

Primary Care Physician____________________________**Phone**________________________

INSURANCE CARDS AND DRIVERS LICENSE OR STATE ID MUST BE PROVIDED TO THE FRONT DESK

My signature authorizes Oakland Ophthalmic Surgery to discuss my treatment and financial status with my immediate family members and/or individuals name YES_______ NO_______

Individuals Names – 1.______________________________ ***2.***______________________________

Authorization: I authorize treatment of my ophthalmic condition by the physicians of Oakland Ophthalmic Surgery, P.C. I authorize the release of any medical or other information necessary to file a claim with my insurance company (including Medicare) and ASSIGN BENEFITS OTHERWISE PAYABLE TO ME to my physician, or the group Oakland Ophthalmic Surgery, P. C. I understand that I am financially responsible for any service that is not a benefit or any balance not covered by my insurance carrier. A copy of this signature is as valid as the original.

____ ____________________

Patient or Responsible Party Date

OAKLAND OPHTHALMIC SURGERY, P.C.

Please complete this form in its entirety.

Name	Date

Social History	
Tobacco use (circle one) Smoker Former Smoker Never Smoked	Alcohol use (circle one) Current drinker Former drinker Never used alcohol
Do you currently drive a car (circle one) yes no	Are you at risk of falling (circle one) yes no
Do you live alone (circle one) yes no Emergency Contact Name ______________________________________ Phone______________________________________	Family Ocular History (circle all that applies) Glaucoma Cataracts Retinal detachment Macular Degeneration Diabetic

ALLERGIES	**REACTION** **RASH** | **SOB** | **Anaphylaxis**	**ALLERGIES**	**REACTION** **RASH** | **SOB** | **Anaphylaxis**

MEDICATION	**DOSE**	**HOW OFTEN**	**WHAT IS THE MEDICATION USED FOR**
Primary Care Physician		**Phone**	
Signature		**Date**	

Complete back of this form

Constitutional	Respiratory	Musculoskeletal	Neurological
○ Patient Denies ○ Fatigue ○ Malaise ○ Chills ○ Fever ○ Appetite Changes ○ Weight Changes	○ Patient Denies ○ COPD ○ Wheezing ○ Cough ○ Hemoptysis ○ Asthma ○ Tuberculosis ○ Shortness of breath	○ Patient Denies ○ Arthritis ○ Swelling ○ Stiffness ○ Muscle Aches ○ Muscle Weakness ○ Leg Cramps ○ Back Pain ○ Joint Pain	○ Patient Denies ○ Alzheimer's ○ Dizziness ○ Headaches ○ Migraines ○ Multiple Sclerosis ○ Neuropathy ○ Paralysis ○ Parkinson's Disease ○ Seizures ○ Stroke ○ TIA ○ Tremors
HEENT ○ Patient Denies ○ Head Injury ○ Decreased Hearing ○ Tinnitus ○ Earache ○ Hay Fever ○ Sinus pain ○ Stuffiness ○ Discharge ○ Dry Mouth ○ Dentures ○ Difficulty swallowing	Gastrointestinal ○ Patient Denies ○ Diarrhea ○ Constipation ○ Stool Changes ○ Hemorrhoids ○ Indigestion ○ Difficulty swallowing ○ Nausea/Vomiting	Psychiatric ○ Patient Denies ○ Depression ○ Nervousness ○ Anxiety ○ Memory Loss ○ Panic Attacks ○ Mania	
Cardiovascular ○ Patient Denies ○ Angina ○ High BP ○ Low BP ○ Murmur ○ Thrombophlebitis ○ Varicose Veins	Genitourinary ○ Patient Denies ○ Blood ○ BPH ○ Difficult Urination ○ Enlarged Prostate ○ Increased Frequency ○ Frequent UTIs ○ Incontinence ○ Kidney Stones	Endocrine ○ Patient Denies ○ Polydipsia ○ Hypoglycemia ○ Diabetes ○ Hypothyroid ○ Hyperthyroid ○ Goiter ○ Head Cold Intolerance	
	Dermatological ○ Patient Denies ○ Rash ○ Lump ○ Itching ○ Dryness	Hematologic ○ Patient Denies ○ Ease of Bruising ○ Excessive Bleeding ○ Enlarged Lymph Nodes ○ Anemia	OAKLAND OPHTHALMIC SURGERY, P.C.

OAKLAND
OPHTHALMIC
SURGERY, P.C.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ THIS NOTICE CAREFULLY.

At the Oakland Ophthalmic Surgery, we believe that your health information is personal. We keep records of the care and services that you receive at our facilities. We are committed to keeping your health information private, and we are also required by law to respect your confidentiality.

This Notice describes the privacy practices of Oakland Ophthalmic Surgery. This Notice applies to all of the health records that identify you and the care you receive at Oakland Ophthalmic Surgery. If you are under 18 years of age, your parents or guardian must sign for you and handle your privacy rights for you. We are legally required to give you this Notice and to follow the terms of the Notice that is currently in effect.

Please review it carefully.

- Oakland Ophthalmic Surgery may disclose your health and/or medical information to treating health care professionals including but not limited to: physicians, nurses, lab technicians, and pharmacists.

- Oakland Ophthalmic Surgery will disclose your health and/or medical information when we are required to do so by Federal, State, or Local Law.

- Oakland Ophthalmic Surgery may disclose your health and/or medical information to third party payers, Insurance companies, and/or billing companies in order to receive payment for the services you received.

- Oakland Ophthalmic Surgery may confirm appointments, leave a medically related message, or leave a message related to your financial account on your home or cell phone, answering machine and/or voicemail, or directly with a person at your home.

- You have the right to inspect and obtain a copy of your health and/or medical information. This request must be in writing, there is a reasonable fee for copying the records.

I have read and agree to the above terms, I was offered a complete copy of Oakland Ophthalmic Surgery's NOTICE OF PRIVACY PRACTICES.

Signature of patient ________________________________ Date ______________________
Guardian must sign for minor

Witness ____ Date ______________________