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PATIENT REGISTRATION FORM

Please Print

Patient Name _____ Social Security # _____

Responsible Party (If different than patient) _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Date of Birth ____/____/____ Sex - M F Marital Status – M S W D

Employer Name _____ Employer Phone _____

Primary Care Physician _____ **Phone** _____

INSURANCE INFORMATION

Primary Insurance _____

Subscribers Name (If different from responsible party) _____

Patient Relationship to Subscriber _____ **Subscriber Birthdate** _____

Secondary Insurance _____

Insured Person's Name (If different from responsible party) _____

Patient Relationship to Subscriber _____ **Subscriber Birthdate** _____

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

PATIENT QUESTIONNAIRE

NAME:	D.O.B.:
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Medical history review:

MEDICATION	Used for:

MEDICATION	Used for:

I am allergic to: _____

System	No	Comments
Central Nervous System/Skeletal <input type="checkbox"/> Stroke <input type="checkbox"/> Seizure <input type="checkbox"/> Arthritis <input type="checkbox"/> Migraines <input type="checkbox"/> M.S. <input type="checkbox"/> Parkinson's <input type="checkbox"/> Alzheimer's <input type="checkbox"/> Dementia <input type="checkbox"/> Other		
Cardiovascular <input type="checkbox"/> Hypertension <input type="checkbox"/> Angina <input type="checkbox"/> Heart Attack <input type="checkbox"/> CHF <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Pacemaker <input type="checkbox"/> ICD <input type="checkbox"/> Coronary Artery Disease <input type="checkbox"/> Other		
Gastrointestinal <input type="checkbox"/> Ulcers <input type="checkbox"/> Hiatal hernia/Reflux <input type="checkbox"/> Other		
Hematologic <input type="checkbox"/> Anemia <input type="checkbox"/> Bleeding Tendency <input type="checkbox"/> Other		
Autoimmune Disorders <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Lupus <input type="checkbox"/> Grave's Disease <input type="checkbox"/> Hashimoto's Thyroiditis <input type="checkbox"/> Sjogren's <input type="checkbox"/> Crohn's <input type="checkbox"/> Ulcerative Colitis <input type="checkbox"/> Polymyalgia <input type="checkbox"/> Other		
Miscellaneous <input type="checkbox"/> Diabetes <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Allergies <input type="checkbox"/> Sinus <input type="checkbox"/> Hepatitis <input type="checkbox"/> Enlarged Prostate <input type="checkbox"/> Mersa <input type="checkbox"/> HIV <input type="checkbox"/> Other		
FAMILY OCULAR HISTORY <input type="checkbox"/> Glaucoma <input type="checkbox"/> Cataracts <input type="checkbox"/> Retinal detachment <input type="checkbox"/> Macular Degeneration <input type="checkbox"/> Diabetic		

Have you ever been diagnosed with cancer? No Yes, please specify _____

Do you wear a hearing aid? No Yes

Recent surgeries: _____

Social history review:

Smoking: I have never smoked. I am a former smoker. I smoke currently.

Alcohol: Number of drink(s) _____ per _____

Primary care physician: _____ Phone # _____

INFORMATION OBTAINED FROM: Patient Spouse Parent Other

SIGNATURE: _____ DATE: _____

Emergency Contact: _____ Phone: _____



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 _____