

Welcome to Our Practice
Patient Registration

Date: _____

Patient's Last Name _____ First _____ M.I. _____
Address _____
City _____ State _____ Zip _____
Date of Birth _____ Age _____ Sex _____ M _____ F _____
Social Security # _____ Cell Phone # _____
Home Phone _____ E-mail _____

Family Physician _____ Telephone _____
Address _____
Eye Doctor _____ Telephone _____
Address _____
Local Pharmacy _____ Telephone _____
Address _____

Patient's Employer _____
Work Address _____
Work Phone _____
Occupation _____ Full / Part Time _____ Student _____
Is your condition or injury work related? No _____ Yes _____ Date of injury _____

If the patient is a minor:

Mothers Name _____
DOB _____ Social Security # _____
Address If Different: _____

Fathers Name _____
DOB _____ Social Security _____
Address if Different: _____

Home phone _____
Employer _____
Address _____
Work Phone _____

Home Phone _____
Employer _____
Address _____
Work Phone _____

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Person Responsible for Payment (If patient is a minor, parent or guardian)

The person who requests treatment is responsible for all fees for services rendered.

Name _____ Relationship _____
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Primary Insurance Information (we would like to photocopy your card).

Name of Ins Company _____ Ins Phone Number _____
ID or Policy Number _____
Group Number or Plan Number _____
Address to send claim forms _____
City _____ State _____ Zip _____
Subscriber's name _____ DOB _____
Social Security Number _____
Patient's Relationship to the Subscriber _____ Self _____ Spouse _____ Child _____ Other _____

Secondary Insurance Information (we would like to photocopy your card).

Name of Insurance Company _____
Telephone Number _____
Group Number or Plan number _____
Address to send claim forms _____
City _____ State _____ Zip _____
Subscriber's name _____ DOB _____
Patient's Relationship to the Subscriber _____ Self _____ Spouse _____ Child _____ Other _____
Social Security Number _____

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How did you learn about Dr. Wasserman (Please check all that apply)

___ Radio Which Station _____
___ Google _____
___ TV _____
___ Referred by Doctor _____ Referred by someone who had LASIK _____
___ Referred by a Family Member _____ Other _____

Please include the name of the person who referred you. We want to be sure to thank them. The best compliment any patient can give us is to refer their friends and family.

Name _____
Relationship to Patient _____
Address _____
City _____ State _____ Zip _____

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In case of Emergency

Please notify

Name _____
Relationship _____ Phone _____

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Private Insurance Authorization For Assignment of Benefits and Release of Information

I hereby authorize and direct payment of my medical benefits to Barry N. Wasserman, M.D., LLC, for any services furnished to me by the physicians. I understand that I am financially responsible for payment of any services for supplies that are deemed not medically necessary or non-covered by my insurance company. This includes refractions, contact lens examinations, and supplies. It is my responsibility to notify this office of any change in my insurance plan before I visit. I further understand that I am responsible for charges incurred when my insurance coverage has been changed or terminated. I also authorize my insurance company to release any information required to process claims of benefits.

Patient (or responsible party) Signature

Date

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Medicare Lifetime Signature on File

I request payment of authorized MEDICARE benefits be made either to me or on my behalf to Barry N. Wasserman, M.D., LLC, for any services furnished to me by the physicians. I authorize any holder of medical information to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

Patient (or responsible party) Signature

Date

Medical History Questionnaire

Name: _____ Date: _____

Do you wear glasses (circle) **YES** or **NO** If yes, how long have you had the current pair? _____

Do you wear contacts (circle) **YES** or **NO** If yes, how long have you had the current pair? _____

Do you have an interest in refractive surgery, LASIK (corrects nearsightedness, farsightedness and astigmatism) **YES** or **NO**

List any medications, including eye drops that you take: _____

List any vitamins, nutritional supplements or herbs that you take: _____

Do you have (circle) **DIABETES** / **HEART DISEASE** / **HIGH BLOOD PRESSURE**?

List all major illnesses and injuries (Date) _____

List surgeries you have had: _____

Allergies to any medications or foods: Sulfa Drugs / Fluorescein Dye-Iodine-Penicillin

If others, please list: _____

Do you have any cultural/language/visual/auditory and religious factors affecting your care?

Yes or **No**

Do you have an advance directive on file (e.g. living will or durable power of attorney for health care) if you are 18 years or older? **Yes** or **NO**

Preferred Language _____ Race _____ Ethnicity _____

Do you currently have any problems in the following areas? Provide additional information for any "Yes" answer below.

Constitutional Symptoms	Yes	No	Eyes con't	Yes	No
Fever			Sandy or gritty feeling		
Weight Loss			Itching		
Fatigue			Burning		
Eyes			Foreign body sensation		
Loss of vision			Excess tearing/watering		
Blurred vision			Occasional tearing		
Loss of side vision			Glare/light sensitive		
Double vision			Eye pain or soreness		
Dryness			Chronic infection of eye or lid		
Mucous discharge			Sty or Chalazion		
Redness			Fluctuating visual acuity		

Please explain all "Yes" answers here: _____

Physician signature _____ Date _____

Ears, nose, mouth and Throat	Yes	No	Ear, nose, mouth and throat cont	Yes	No
Sinus Congestion			Psychiatric depression, anxiety		
Runny nose/post nasal drip			Family History		
Chronic cough			Blindness		
Dry or sore throat/mouth			Cataract		
Respiratory:shortness of breath			Glaucoma		
Cardiovascular heart failure/heart attack			Macular degeneration		
Irregular heart beat			Retinal detachment		
Gastrointestinal			Arthritis		
Ulcers, heartburn			Cancer		
Urinary pain or discomfort			Diabetes		
Musculoskeletal			Heart Disease		
Skin rashes, dryness, moles, cancer			High blood pressure		
Neurological numbness, weakness			Kidney disease		
Migraine headaches			Lupus		
Stroke			Sjogrens' disease		
Endocrine heat or cold intolerance			Stroke		
Bleeding/bruising			Thyroid disease		
Allergic/immunologic/HIV or AIDS			Tuberculosis		
Allergy symptoms sneezing, itching			Other		

Please explain all "Yes" answers here: _____

Social History

Current occupation or retired from: _____

Do you drive: Yes No

Difficulty with Driving Yes No, If yes, please explain _____

Problems with night vision Yes No If yes, please explain _____

Do you drink alcohol Yes No If yes, number or drinks per week _____

Do you smoke Yes No If yes number of packs per day _____

Have you ever had a blood transfusion Yes No If yes please explain: _____

Have you ever been treated or exposed to an infectious disease (circle) Hepatitis A/ B / C
HIV or AIDS / Syphilis

BARRY WASSERMAN, MD

RECEIPT

RECEIPT OF NOTICE OF PRIVACY PRACTICES (Version 4/03)
IS HEREBY ACKNOWLEDGED:

Signature of Patient or Guardian Print Name Date

If signed by guardian or Power of Attorney, name of patient:

The patient, or person signing for the patient named above, acknowledges receipt of a federally-required Notice of Privacy Practices, provided to you under the provisions of the Health Insurance Portability and Accountability Act of 1996. The notice describes how medical information about you (or the patient, if you are someone signing for the patient) may be used and disclosed, and how you can get access to this information. You also have certain other privacy rights under federal law, and these rights are described more fully in the Notice. You have been given a copy to take with you. Please review it carefully. The Notice helps you understand all the uses and disclosures that may be made of your medical information, and it describes your privacy rights. The Notice also indicates who you should contact if you have questions about your privacy rights. This receipt will be kept in your patient record to document that you have received this required Notice.