CORESIGHT NEURO-OPHTHALMOLOGY - PATIENT REGISTRATION

Name: _____ **Date of Birth**: _____

Address: _____ **City**: _____ **State**: _____ **Zip**: _____

Social Security #: _____ **Phone**: _____ **Alt. Phone**: _____

Phone number that we can text:_____ **Emergency Contact:** _____

Relationship to Emergency Contact: _____ **Phone**: _____

Marital Status: _____ **Employment Status (Please circle)**: Employed Unemployed Retired Student

Race: Native Hawaiian Caucasian African American Asian **Ethnicity**: Hispanic/Latino Not Hispanic/Latino

Name of Primary Care Physician: _____**Primary Care Physician Phone:**_____

PHARMACY DETAILS

Name of pharmacy:_____**Pharmacy Phone**: _____

Pharmacy address: _____ **City**: _____ **State**: _____ **Zip**: _____

INSURANCE DETAILS

Primary Insurance Name: _____ **Name of Insured**: _____

Policy #: _____ **Group #**: _____

Secondary Insurance Name: _____ **Name of Insured**: _____

Policy #: _____ **Group #**: _____

If you are not the subscriber, please list his/her name, date of birth, and relationship to patient below.

Name: _____ **DOB**: _____ **Relationship to Patient**: _____

MISSED APPOINTMENT POLICY

Unless canceled at least 48 hours in advance, our policy is to charge a MISSED/NO SHOW FEE of $40.00. Your insurance company will not pay for this fee.

_____ **Initial that you have read the Missed Appointment Policy.**

RELEASE OF MEDICAL INFORMATION STATEMENT

Please provide the names of individuals with whom we can share your medical information. If the name is not listed on this form, we will not disclose any information.

_____

I hereby give my consent to CORESIGHT and/or the physician, practitioner's employee by CORESIGHT to provide requested information from my medical record to third party payers and/or other health care providers deemed necessary.

_____ **Initial that you have read and agree to the Release of Medical Information Statement.**

ASSIGNMENT OF BENEFITS

I understand that I am responsible for all charges on my account regardless of insurance. I authorize payment of any benefits due from my insurance company to CORESIGHT for services rendered to myself and/or my dependents.

Signature: **X** _____ **Date**: _____

Printed Name: _____ **Relationship to Patient**: _____

Name: _____ **Date of Birth**: _____

SOCIAL HISTORY

Tobacco Use: _____ **Type / Amount per Day:** _____

Alcohol Usage: _____ **Type / Amount per Day**: _____

Recreational Drug Usage: _____ **Type / Amount per Day**: _____

Occupation: _____ **Do you drive?**: _____

PAST MEDICAL HISTORY

Have you ever had…?

Illness	Yes	No	Illness	Yes	No	Illness	Yes	No
Anemia			Heart Disease (specify what type)			Lupus		
Asthma			High Cholesterol			Mental Illness (depression/anxiety/bipolar)		
Cancer (specify what type)			Hypertension			Pulmonary Embolism		
COPD			Hypothyroidism			Rheumatoid Arthritis		
Diabetes Type I			Hyperthyroidism			Stroke		
Diabetes Type II			Lung Disease (specify what type)			Traumatic Brain Injury		
Other:								

Details: _____

PAST OCULAR HISTORY

Have you ever had…?

Illness	Yes	No	Illness	Yes	No	Illness	Yes	No
Cataracts (which eye?)			Dry Eyes			Glaucoma		
Contact use			Eye Trauma (which eye?)			Macular Degeneration		
Other:								

Details: _____

Name: _____ **Date of Birth:** _____

FAMILY MEDICAL HISTORY

Please list those who have poor health or are deceased.

Relationship (Please specify maternal/paternal)	Age	Medical Conditions / Cause of Death

SURGICAL AND HOSPITALIZATION HISTORY

Please list approximate dates and reasons for surgeries/hospitalizations.

_____

_____

_____

MEDICATIONS

Please list current medications

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ALLERGIES

Please list any allergies

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Name: _____ **Date of Birth:** _____

REVIEW OF SYSTEMS

Have you recently had. . .?

CONSTITUTIONAL	**Yes**	**No**	**CARDIAC**	**Yes**	**No**	**HEMATOLOGY/IMMUNOLOGY**	**Yes**	**No**
Fever			Chest Pain			Pallor		
HEAD	**Yes**	**No**	Palpitations			Spontaneous or easy bruising and/or bleeding		
Headaches			Syncope (Fainting due to fall in blood pressure)			Lymph Node pain or swelling		
Dizziness			**RESPIRATORY**	**Yes**	**No**	Recurrent Infections		
EYES	**Yes**	**No**	Cough			**JOINTS**	**Yes**	**No**
Diplopia (Double vision)			Sputum Production			Arthralgia (pain in joints)		
Scotoma (Partial vision loss or blind spot)			Hemoptysis (Coughing blood)			Arthritis		
EAR	**Yes**	**No**	Dyspnea (Shortness of breath)					
Eye pain			**GASTROINTESTINAL**	**Yes**	**No**	**NEUROLOGIC**	**Yes**	**No**
Eye Discharge			Dysphagia (Difficulty swallowing)			Seizures		
Photophobia (Sensitivity to light)			Hematemesis (Vomiting blood)			Loss of Consciousness		
Otalgia (Ear pain)			**GENITO-URINARY**	**Yes**	**No**	Gait imbalance		
Tinnitus (Ringing in ears)			Flank Pain (pain in side)			**DERMATOLOGIC**	**Yes**	**No**
Vertigo (Spinning sensation)			Dysuria (Painful urination)			Hyperpigmentation		
MOUTH	**Yes**	**No**	Hematuria (Blood in urine)			Rash		
Bleeding			Difficulty initiating urination			Photosensitivity (sun allergy)		
Ulceration (open sore)			**ENDOCRINE**	**Yes**	**No**			
Glossodynia (Burning sensation in mouth)			Polydipsia (Excessive thirst)					
Xerostomia (Dry mouth)			Polyuria (Excessive urination)					
THROAT	**Yes**	**No**	Hyperactivity					
Sore Throat			Galactorrhea (Excessive or inappropriate milk secretion from breast)					
Hoarseness			Gynecomastia (Enlarged breast in men)					