CORESIGHT NEURO-OPHTHALMOLOGY - PATIENT REGISTRATION

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

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

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

Emergency Contact / Relationship: _____ **Phone**: _____

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

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

Primary Language: _____

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 $30.00. Your insurance company will not pay for this fee.

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

PRIVACY PRACTICES POLICY

By initialing below you acknowledge that you have received and had an opportunity to ask questions regarding the CORESIGHT Notice of Privacy Practices.

_____ **Initial that you have read the Privacy Practices 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

ALLERGIES

Please list any allergies

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

REVIEW OF SYSTEMS

Have you recently had. . .?

CONSTITUTIONAL	**Yes**	**No**	**CARDIAC**	**Yes**	**No**	Milk secretion from breast		
Fever			Palpitations			Enlarged breast (in men)		
HEAD	**Yes**	**No**	Fainting due to blood pressure			**HEMATOLOGY/IMMUNOLOGY**	**Yes**	**No**
Headaches			Chest pain			Pallor		
Dizziness			**RESPIRATORY**	**Yes**	**No**	Easy bruising		
Double vision			Cough			Lymph Node pain or swelling		
Partial vision loss or blind spot			Sputum Production			Recurrent Infections		
Eye pain			Coughing blood			stiffness		
Eye Discharge			Shortness of breath			Swelling of joints		
Sensitivity to light			**GASTROINTESTINAL**	**Yes**	**No**	**DERMATOLOGIC**	**Yes**	**No**
Ear pain			Difficulty swallowing			Skin pigmentation		
Ringing in ears			Vomiting blood			Rash		
Spinning sensation			**GENITO-URINARY**	**Yes**	**No**	Light sensitivity		
MOUTH	**Yes**	**No**	Side pain			**NEUROLOGIC**	**Yes**	**No**
Bleeding			Painful urination			Seizures		
Ulceration (open sore)			Blood in urine			Syncope (passing out)		
Burning sensation in mouth			Difficulty initiating urination			Gait imbalance		
Dry mouth			**ENDOCRINE**	**Yes**	**No**			
THROAT	**Yes**	**No**	Excessive thirst					
Sore Throat			Excessive urination					
Hoarseness			Hyperactivity					