CORESIGHT NEURO-OPHTHALMOLOGY

PATIENT REGISTRATION

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

Address: _____

City: _____ **State**: _____ **Zip**: _____ **Social Security #**: _____

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

Emergency Contact Phone: _____ **Marital Status**: _____

Employment Status: Employed Unemployed Retired Student (**Please circle appropriate status**)

Race: Caucasian Affrican American Asian 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 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: _____

Allergies:_----------

PAST MEDICAL HISTORY

Have you ever had…?

Illness	Yes	No	Illness	Yes	No	Illness	Yes	No
Asthma/COPD			Heart Disease			Mental Illness		
Cancer			Hepatitis			Thyroid disorder		
Diabetes			HIgh Cholestrol			Seizure Disorder		
Rheumatoid Arthritis			Hypertension			Stroke		
Lupus			Lung Disease			Venereal Disease		
Other: Glaucoma, Macular Degeneration, Eye Trauma, Cataract, Dry Eyes.								

Details: _____

_____

FAMILY MEDICAL HISTORY

Please list those who have poor health or are deceased.

Relationship	Age	Medical Conditions / Cause of Death

SURGICAL AND HOSPITALIZATION HISTORY

Please list approximate dates and reasons for surgeries/hospitalizations.

_____

_____

_____

Name: _____ Date of Birth: _____

REVIEW OF SYSTEMS

Have you recently had…?

CONSTITUTIONAL	YES	NO	**GASTROINTESTINAL**	YES	NO
Fever			Difficulty swollowing		
Chills			Vomiting blood		
Malaise			Abdominal Pain		
HEAD			Blood in stool		
Headaches			**GENITO-URINARY**		
Dizziness			Flank Pain		
EYE			Painful urination		
Double vision			Blood in urine		
Scotoma			Pus in Urine		
Eye pain			**ENDOCRINE**		
Eye discharege			Excessive thirst		
Photophobia			Excessive urination		
Exophthalmos			Excessive eating		
EAR			Lethargy		
Otalgia (ear pain)			Hyperactivity		
Otorrhea (ear discharge)			Milk secretion from the breast		
Tinnitus			Enlarged breast (in Men)		
Vertigo			Flushing		
NOSE			**HEMATOLOGY / IMMUNOLOGY**		
Epistaxis			Pallor		
Rhinorrhea			Easy bruising		
MOUTH			Lymph Node pain or swelling		
Bleeding			Recurrent Infections		
Ulceration			Raynaud's Phenomenon		
Dry mouth			**MUSCLES**		
THROUT			Weakness		
Sore throat			Myalgia		
Hoarsness			Atrophy		

Name: _____ Date of Birth: _____

CARDIOVASCULAR	YES	NO
Chest pain		
Palpitation		
Syncope		
Night Cramps		
Orthostasis		
RESPIRATORY		
Cough		
Sputum Production		
Hemoptysis (coughing blood)		
Shortness of breath		
Wheezing		

JOINTS	YES	NO
Pain		
Stiffness		
NEUROLOGICAL		
Headaches		
Loss of consciousness		
Seizures		
DERMATOLOGIC		
Hyperpigmentation Rash		
Photosensitivity		

CURRENT MEDICATIONS

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