NEVADA RETINA CENTER

Tyson Ward, MD Chris Wu, MD

Patient Registration Form

		Today's Date:
Name: Last, First, MI	Nickname:	Gender: (circle one) M F other
If Minor, Responsible Parent/Guardian's Name/Relation to patient:		Patient's Date of Birth:
Marital Status: Married☐ Divorced☐ Single☐ Widowed☐ Separated☐		**SS Number:**
Preferred Language:	Ethnicity/Race: ☐ Decline to answer Ethnicity/race	Smoker? Yes☐ No☐ Former☐ Veteran Yes ☐ No ☐
Home Address:	City:	State: Zip:
Home Phone:	Cell Phone:	Work Phone:
Preferred Contact Method: Home☐ Cell☐ Work ☐	Email Address:	
Employer:		Employer Ph#
Primary Care Physician Name:		PCP Ph#
Referring Physician Name (if different from above):		Ref Phys Ph#
Preferred Pharmacy:		Pharmacy Ph#
Emergency Contact: Relation to patient:		Emergency Ph#

Medical Insurance Information

Primary Insurance:	Primary Policy Number:	
Insured's Name/ Relation to patient:	Insured's Date of Birth:	Insured's SSN:
Secondary Insurance:	Secondary Policy Number:	
Insured's Name/ Relation to patient:	Insured's Date of Birth:	Insured's SSN:

I hereby authorize Nevada Retina Center to release all medical information regarding my illness, care and/or injury to my insurance carriers, any health care facility, and any other physician that would benefit my health care. I hereby assign Nevada Retina Center all payments to which I am entitled for medical/surgical expenses related to the services reported from the above. I understand that copay(s) are due at time of service.

Signature of Patient or Responsible Party Printed Name Date form signed

Financial Agreement

Thank you for choosing Nevada Retina Center for your eye care needs. We are pleased to welcome you to our practice. Our chief concern is that you and your family receive the finest care and treatment. Please be advised that you, the patient, are responsible for understanding the insurance plan you have selected and meet all the requirements to fulfill contractual agreements between your plan and our practice.

As a courtesy, we will be glad to submit your claims to your insurance carrier for payment, however, the final responsibility of payment due for services rendered is the sole liability of you, the patient or the guarantor. Prior authorization does not guarantee payment of services, and if a referral is required from your insurance carrier you will be responsible for obtaining one prior to your visit. **The patient is responsible for all charges not paid by the insurance company.** At the time of your visit, please present all necessary information to avoid nonpayment by your insurance carrier, which includes insured party's information, current insurance card(s), any required insurance referral and accurate completion of registration paperwork. If we do not participate with your insurance carrier, payment is due at the time of service. Further, I authorize release of my medical information to referring providers, consultants and insurance company.

PAYMENT/COPAYS/DEDUCTIBLES ARE DUE AT TIME OF SERVICE.

We accept payment in the form of Visa, MasterCard, Discover, American Express, cash and check.

We understand that occasionally some of our patients will experience financial difficulties. It is our hope that you will bring these situations to the attention of our billing department or office manager to allow us to help manage your account in the most effective way.

_____	_____	_____
Print Name	Signature of Patient or Guardian	Date

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HIPPA 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 REVIEW IT CAREFULLY.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected healthy information. “Protected health information” is information about you, including demographic information that may identify you and that is related to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital procedure may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We use a sign in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We will also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary to provide, schedule, and/or arrange your care.

I acknowledge that I have the right to revoke this authorization at any time, and I understand that once the information is disclosed, it may no longer be protected by the Federal Privacy Law. Copies of this authorization may serve as the original.

I understand that I have been given the opportunity to read the Notice of Privacy Practices posted in the office and is available in hard copy upon my request.

Date: _____

Patient Name (Print): _____

Patient Signature: _____

Parent/Guardian Signature:_____

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Preferred Pharmacy Information

Please complete the following information for the Pharmacy that you would like any prescriptions sent to.

Patient Name_____Date_____

Pharmacy Name_____

Pharmacy Address_____

Pharmacy Phone Number_____

Medical Questionnaire

PATIENT NAME: _____ **DATE OF BIRTH: _____**

Medication Allergies: □ **None** □ **Penicillin** □ **Sulfa** □ **Fluorescein** □ **Shellfish**

□ **Iodide Contrast Dye** □ **Other: _____**

Current Medications: _____

_____

_____

_____

Review of Systems: (Please mark all that apply)

General (Constitutional)
□ Fever
□ Weight Loss/Gain
□ Fatigue
□ Irritability

HEENT
□ Headache
□ Eye Pain
□ Floaters / Flashes
□ Vision Loss
□ Hearing Loss
□ Vertigo
□ Nasal Drainage
□ Nasal Congestion

Respiratory
□ Cough
□ Shortness of Breath
□ Wheezing

Gastrointestinal
□ Bloating
□ Constipation
□ Diarrhea
□ Nausea
□ Vomiting

Genitourinary
□ Cloudy Urine
□ Urgency
□ Painful Urination

Neuro/Psychiatric
□ Dizziness
□ Headache
□ Seizure
□ Weakness

Cardiovascular
□ Chest Pain
□ Edema
□ Irregular Heart Beat

Muscoloskeletal
□ Back Pain
□ Muscle Weakness
□ Neck Stiffness

Hematologic
□ Easy Bruising
□ Easy Bleeding

Dermatologic
□ Hair Loss
□ Rash
□ Skin Lesion

Ocular Surgeries

□ Blepharoplasty	R L	□ Retinal Detachment	R L	□ Vitrectomy R L
□ Cataract	R L	□ LASIK	R L	□ Other: _____
□ Corneal Transplant	R L	□ Strabismus	R L	_____
□ Retinal Laser	R L	□ Glaucoma	R L	_____

Ocular History

Do you or any member of your immediate family have any of the following eye diseases:

Disease	You		Family Member	
Glaucoma	Yes	No	Yes	No
Cataract	Yes	No	Yes	No
Amblyopia (Lazy Eye)	Yes	No	Yes	No
Macular Degeneration	Yes	No	Yes	No
Retinal Detachment	Yes	No	Yes	No
Retinal Disease	Yes	No	Yes	No
Diabetic Retinopathy	Yes	No	Yes	No
Other Eye Problem	Yes	No (if yes, specify)	Yes	No (if yes, specify)

Medical History

Do you have now, or have you had in the past:

Angina	Yes	No	Migraine	Yes	No
Anxiety	Yes	No	Heart Disease	Yes	No
Arthritis	Yes	No	Hepatitis	Yes	No
Asthma	Yes	No	Hypertension	Yes	No
Cancer	Yes	No	Osteoporosis	Yes	No
COPD	Yes	No	Seizure Disorder	Yes	No
Depression	Yes	No	Stroke	Yes	No
Diabetes	Yes	No	Thyroid Disease	Yes	No
High Cholesterol	Yes	No	Other:_____		
			_____		

Surgical History

□ Angioplasty
□ Appendectomy
□ Arthroscopy
□ Back Surgery
□ Blood Transfusion
□ CABG
□ CABG
□ Cardiac Pacemaker
□ Carpal Tunnel Release
□ Cholecystectomy
□ Colectomy
□ Gastric Bypass
□ Hernia Repair
□ Hip Replacement
□ Knee Replacement
□ Thyroidectomy
□ Tonsillectomy
□ Other: _____

Family History

□ Arthritis
□ Asthma
□ Blindness
□ Cancer
□ Stroke
□ Colitis
□ Crohn's Disease
□ Diabetes
□ Elevated Lipids
□ Hypertension
□ Lupus
□ Migraines
□ Multiple Sclerosis
□ Renal Disease
□ Retinal Disease
□ Seizure Disorder
□ Cardiovascular Disease
□ Other: _____

Social History

Do you smoke? □ Yes □ No □ Former Smoker
If yes, what kind? □ Cigar □ Pipe □ Cigarette

Do you drink alcohol? □ Yes □ No
If yes, please list type, amount, and frequency. _____