REGISTRATION (PLEASE PRINT)

Date__________________ Home Phone________________________ Cell_________________

Email Address ____

PATIENT INFORMATION

Name____ Soc Sec#______________________
(Last) (First) (Initial)

Address____

City____ State____________ Zip________

Sex ☐ M ☐ F Age___________________ Birthday__________________________________

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Race - ☐ Asian ☐ White ☐ Black/African American ☐ American Indian ☐ Refuse to Answer

Ethnicity - ☐ Hispanic/Latino ☐ Non Hispanic/Latino ☐ Refuse to Answer

Employer____________________________________ Occupation_______________________

Address____Phone____________

Primary Care Physician: ________________________________Phone:_________________

Whom may we thank for referring you?____

In case of emergency notify?___________________________________ Phone__________

Your Pharmacy (Name & Phone Number):______________________________________

PRIMARY INSURANCE

Person Responsible for Account____
(Last) (First) (initial)

Relation to Patient_________________ Birthday_____________ Soc Sec#______________

Address____

City____ State_________ Zip____________

Person Responsible Employed By__________________________ Occupation______________

Business Address____ Phone________________

Insurance Carrier____

Contract#____________________ Group#___________________ Subscriber#____________

Names of other dependents covered____

HELIX EYE CARE

REGISTRATION CON'T (PLEASE PRINT)

ADDITIONAL INSURANCE

Is Patient Covered By Additional Insurance? ☐ YES ☐ NO

Subscriber Name__________________Relation to Patient________________ Birthdate_________

Address____

City____ State__________ Zip_______________

Subscriber Employed By___________________________________ Phone_________________

Insurance Carrier____________________________________ Soc Sec#___________________

Contract#_____________________ Group#____________________ Subscriber#_____________

Names of other dependents covered____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with ___________________________
Insurance Company(ies)

and assign directly to Dr._____Wang/Dwarakanathan/Raiji/Diab____all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand I will be responsible for all fees incurred including collection and attorney fees and any/all court costs on balances over 90 days. I further agree upon default, to pay interest accruing at a rate of 1.5% (18% annum) on any unpaid balances. I hereby authorize the doctor to release all information necessary to secure the benefits. I authorize the use of this signature on all insurance submissions.

NO-SHOW FEE

Failure to cancel at least 24 hours before your scheduled appointment will result in a no-show fee. This fee will not be billed to your insurance company and must be paid before your next appointment.

____ ________________________ ________________________

Responsible Party Signature Relationship Date

DATE: ______________________

PATIENT NAME: ______________________

ALLERGIES: ______________________

MEDICATIONS (NAME, DOSAGE, AND FREQUENCY - FOR EYE MEDS PLEASE SPECIFY WHICH EYE):

____

____

____

____

____

____

____

____

SMOKE: NO ______ YES ______ FORMER SMOKER? NO ______ YES ______

DRINK: NO ______ YES ______ HOW OFTEN? ______________

DRUGS: NO ______ YES ______ DRUGS USED? ______________

HOW MUCH? ______________ HOW LONG? ______________

FAMILY HISTORY (EYE OR OTHER DISEASES): ______________________

____

OCULAR HISTORY: ______________________

____

PAST OCULAR SURGERIES: ______________________

____

MEDICAL HISTORY: ______________________

____

PAST MEDICAL SURGERIES: ______________________

____

DATE: ______________________

PATIENT NAME: ______________________ PATIENT WT: ______________ PATIENT HEIGHT: ______________

EYES

Previous Surgery	□ YES	□ NO
Contact Lens	□ YES	□ NO
Pain	□ YES	□ NO
Double Vision	□ YES	□ NO
Glaucoma	□ YES	□ NO
Cataracts	□ YES	□ NO
Macular Degeneration	□ YES	□ NO
Dry Eyes	□ YES	□ NO
Flashes	□ YES	□ NO
Floaters	□ YES	□ NO

EAR/NOSE/THROAT

Hard of Hearing	□ YES	□ NO
Ringing in Ears	□ YES	□ NO
Vertigo	□ YES	□ NO

CARDIOVASCULAR

Chest Pain	□ YES	□ NO
Dizziness	□ YES	□ NO
Fainting Spells	□ YES	□ NO
Shortness of Breath	□ YES	□ NO
Irregular Heart Beat	□ YES	□ NO
Difficulty Lying Flat	□ YES	□ NO

CONSTITUTIONAL

Fatigue/Weakness	□ YES	□ NO
Fever	□ YES	□ NO
Weight Gain/Loss	□ YES	□ NO

RESPIRATORY

Cough	□ YES	□ NO
Congestion	□ YES	□ NO
Wheezing	□ YES	□ NO
Asthma	□ YES	□ NO

GASTROINTESTINAL

Heartburn	□ YES	□ NO
Nausea/Vomiting	□ YES	□ NO
Jaundice/Hepatitis	□ YES	□ NO

GENITO-URINARY

Pain/Difficulty	□ YES	□ NO
Blood in Urine	□ YES	□ NO
History of Kidney Stones	□ YES	□ NO
History of STD's	□ YES	□ NO

PSYCHIATRIC

Anxiety/Depression	□ YES	□ NO
Mood Swings	□ YES	□ NO
Difficulty Sleeping	□ YES	□ NO

ENDOCRINE

Increased Thirst	□ YES	□ NO
Increased Hunger	□ YES	□ NO
Increased Urination	□ YES	□ NO
Increased Sweating	□ YES	□ NO
Fingernail Changes	□ YES	□ NO

BLOOD/LYMPHNODES

Easy Bruising	□ YES	□ NO
Gums Bleed Easily	□ YES	□ NO
Prolonged Bleeding	□ YES	□ NO
Heavy Aspirin Use	□ YES	□ NO

MUSCULOSKETAL

Stiffness	□ YES	□ NO
Arthritis	□ YES	□ NO
Joint Pain/Swelling	□ YES	□ NO

SKIN

Rash/Sores	□ YES	□ NO
Lesions	□ YES	□ NO
Hives/Eczema	□ YES	□ NO

NEUROLOGICAL

Seizures	□ YES	□ NO
Weakness/Paralysis	□ YES	□ NO
Numbness	□ YES	□ NO
Tremors	□ YES	□ NO

IMMUNOLOGIC

Hives	□ YES	□ NO
Itching	□ YES	□ NO
Runny Nose	□ YES	□ NO
Sinus Pressure	□ YES	□ NO