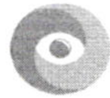

REGISTRATION (PLEASE PRINT)

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___________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): ______________________

____

PAST OCULAR HISTORY: ______________________

____

PAST OCULAR SURGERIES: ______________________

____

PAST 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