HELIX EYE CARE

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_____

ID#_____ Group#_____ Plan#_____

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#_____

ID#_____ Group#_____ Plan#_____

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/Diab/Chiranand/Ittiara__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 $25.00 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

HELIX EYE CARE

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: _____

PAST MEDICAL SURGERIES: _____

_____

MEDICAL HISTORY:

	Yes	No		Yes	No
Diabetes			Cancer		
High Blood Pressure			Hepatitis		
High Cholesterol			AIDS/HIV		
Heart Disease			Multiple Sclerosis		
Thyroid Issues			Pacemaker		
Kidney Dialysis			Defibrilator		

Other: _____