EYE CARE
OF GEORGIA

NEW PATIENT REGISTRATION FORM

GENERAL INFORMATION (PLEASE PRINT)

DATE: _____

NAME: _____ DOB: __/__/_____ SEX: ____F____M

SS#:___-__-____ MARITAL STATUS: __SINGLE __ MARRIED __ DIVORCED __WIDOWED

EMAIL: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

PRIMARY PHONE :(_____) _____-_____ CELL PHONE: (_____) _____-_____

ALTERNATIVE PHONE: (_____) _____-_____

EMPLOYMENT STATUS: EMPLOYED/NOT EMPLOYED/ RETIRED/ STUDENT

EMPLOYER: _____

EMERGENCY CONTACT: _____ RELATIONSHIP_____PHONE: (___)-____-_____

DOCTOR/PHARMACY INFORMATION

PRIMARY CARE PHYSICIAN: _____ PHONE: _____

REFERRING DOCTOR: _____PHONE:_____

PHARMACY NAME: _____PHONE:_____

INSURANCE INFORMATION

PRIMARY INSURANCE:

NAME: _____

POLICY HOLDERS SSN:_____ DOB: __/__/____

RELATIONSHIP TO INSURED: _____

NAME OF INSURED: _____

SECONDARY INSURANCE:

NAME: _____

POLICY HOLDERS SSN: _____ DOB: __/__/____

RELATIONSHIP TO INSURED: _____

NAME OF INSURED: _____

PATIENT/PARENT/GUARDIAN: _____ DATE_____

EYE CARE OF GEORGIA

FINANCIAL POLICY

We are committed to meeting your health care needs. Our goal is to keep your insurance or other financial arrangements as simple as possible. In order to accomplish this in a cost-effective manner, we ask that you adhere to the following guidelines:

1) YOU ARE ULTIMATELY RESPONSIBLE FOR YOUR BILL. We will file to your insurance as a courtesy to you. Social Security number and insurance cards are required at every visit.

2) It is your responsibility to provide us with your current address, telephone number and insurance information at each visit.

3) It is your responsibility to contact your insurance carrier to confirm that the provider you are seeing is a participant of your plan. If you see a doctor that is not currently on your plan, you will be responsible for payment in full.

4) All co-payments, co-insurance and or deductibles are due at the time of service. We accept CASH, VISA, MASTERCARD, and DISCOVER.

5) Medicare Recipients: We are a participating Medicare practice and thus, will file your Medicare claim. If you have supplemental coverage, we will also file to the supplemental plan. We will collect Medicare's deductible if not covered by a supplemental plan. If you DO NOT have supplemental insurance, it is our policy to collect in full or the remaining Medicare deductible and 20% for any services rendered in the office.

6) Referrals for HMO, HMOx, POS, Medicare Advantage Plans, or Tricare Prime: It is your responsibility to bring any required referrals for treatment at or prior to the visit. If you do not have a referral your visit may be rescheduled or you will be financially responsible for your visit.

7) If you have questions about your insurance, we are happy to help you. However, specific coverage issues should be directed to your insurance company member service department. Their telephone number should be located on your insurance card.

8) If the patient is a minor (17 years old or younger) a parent/ guardian has to be present or a signed consent will be needed for services to be performed.

9) If you are experiencing personal circumstances that will make payment of our charges difficult for you, please contact the office manager at 770-682-3937.

10) We will mail you a monthly statement for any outstanding balances. If you fail to make a payment for services rendered to you, your outstanding balance will be sent to a collection agency. You will be responsible for any fees associated with the collection agency. Late fees are $30 and will be added on any balance over 90 days old.

I acknowledge that I understand and accept this financial policy

_____ _____

Signature Date

EYE CARE OF GEORGIA

CONSENT FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR PAYMENT, TREATMENT, AND HEALTH CARE OPERATIONS

By signing below, you hereby consent Eye Care of Georgia to use or disclose information about you (or another person you have the authority to sign) that is protected under federal law, for the sole purposes of treatment, payment and health care operations. You may refuse to sign this consent form.

If you want to read the Notice of Privacy Practices for Protected Health Information before signing the consent, please ask for a copy. The terms of this notice may change from time to time. You may always get a revised copy of it by asking the Privacy Officer for Eye Care of Georgia.

You have the right to request the Eye Care of Georgia restrict how PHI is used or disclosed to carry out treatment, payment, or health care operations. Eye Care of Georgia is not required to agree to requested restrictions; however, if Eye Care of Georgia agrees to your requested restrictions, the restriction is binding on it.

Information about you is protected under federal law, and you have the right to revoke this consent, unless we have taken action in reliance on your authorization (as determined by the Privacy Officer). By signing below, you recognize that the protected health information used to disclose pursuant to this consent may be subject to re-disclosure by the recipient and may no longer be protected under federal law.

DO WE HAVE PERMISSION TO:

Leave a message on your answering machine at home or cellular phone? _____Yes_____No

Leave a message at your place of employment? _____Yes_____No

Discuss your medical condition with any member of your household? _____Yes_____No

If yes whom?_____

_____ _____
Patient Signature/ Guardian Date

_____ _____ _____
Personal Representative Relationship Date
I have authority to act for the individual

Chirag Parikh, M.D.
316 West Pike Street, Suite 200
Lawrenceville, GA 30046

EYE CARE OF GEORGIA

Tel: (770) 682-3937
Fax: (770) 682-3932

INFORMATION REGARDING DILATING EYE DROPS

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of the eye.

Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it's best if you make arrangements no to drive yourself. It is recommended that you wear a pair of sunglasses when you leave and we provide them at the front desk.

Adverse reaction, such as acute angle-closure glaucoma, may be triggered from dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize Dr. Parikh and/or such assistants as may be designated by him to administer dilating drops. The eye drops are necessary to diagnose my condition. This consent shall be applicable to all future visits with Eye Care of Georgia.

_____ _____

Patient Name Date

_____ _____

Patient Signature Witness Signature

(Or person authorized to sign for patient)

EYE CARE OF GEORGIA

MEDICAL HISTORY QUESTIONAIRE

DATE: _____

LAST NAME: _____ FIRST NAME: _____ MI: ____ DOB: ____/____/_____

SSN: _____-_____-_____ LAST MEDICAL EXAM: ____/____/_____ LAST EYE EXAM: ____/____/_____

NAME OF PRIMARY CARE PHYSICIAN: _____ PHONE: _____

NAME OF REFERRING PHYSICIAN: _____ PHONE: _____

MEDICAL HISTORY

DO YOU HAVE ANY ALLERGIES TO MEDICATIONS? _____NO _____YES

IF YES, EXPLAIN: _____

_____

_____

LIST ANY MEDICATIONS YOU TAKE (INCLUDING EYE DROPS, ORAL CONTRACEPTIVES, ASPIRIN, OVER THE COUNTER MEDICATIONS AND HOME REMEDIES): _____

_____

_____

_____

LIST ALL MAJOR INJURIES, SURGERIES, AND/OR HOSPITALIZATIONS YOU HAVE HAD: _____

_____

_____

LIST ANY OF THE FOLLOWING THAT YOU HAVE HAD: CROSSED OR LAZY EYES, DROOPING OF THE EYELIDS, PROMINENT EYE, GLAUCOMA, RETINAL DISEASE, CATARACTS, EYE INFECTIONS, AND/OR EYE INJURY: _____

_____

_____

HAVE YOU EVER HAD ANY EYE SURGERY (INCLUDING LASER)? PLEASE PROVIDE DATES: _____

_____

_____

ARE YOU PREGNANT AND/OR NURSING? _____ NO _____ YES

DO YOU CURRENTLY WEAR GLASSES? _____ NO _____ YES

IF YES, HOW OLD IS YOUR PRESENT PAIR OF LENSES? _____

DO YOU WEAR CONTACT LENSES? _____ NO _____ YES

IF YES, HOW OLD IS YOUR PRESENT PAIR CONTACT LENSES? _____

WHAT TYPE OF CONTACT LENSES? *RIGID*_____ *SOFT*_____ *EXTENDED WEAR* _____ *DAILY*_____ *MONTHLY*_____ *OTHER BRAND*___

ARE YOUR CONTACT LENSES COMFORTABLE? _____ NO _____ YES

FAMILY HISTORY

**PLEASE NOTE ANY FAMILY HISTORY (PARENTS, GRANDPARENTS, SIBLINGS, CHILDERN, LIVING OR DECEASED) FOR THE FOLLOWING CONDITIONS:*

DISEASE/CONDITIONS	YES	NO	RELATIONSHIP TO YOU
BLINDNESS			
CATARACTS			
CROSSED EYES			
GLAUCOMA			
MACULAR DEGENERATION			
RETINAL DETACHMENT/DISEASE			
ARTHRITIS			
CANCER			
DIABETES			
HEART DISEASE			
HIGH BLOOD PRESSURE			
KIDNEY DISEASE			
LUPUS			
THYROID DISEASE			
OTHER: _____			

EYE CARE OF GEORGIA

REVIEW OF SYMPTOMS – PATIENT MEDICAL HISTORY

** DO YOU CURRENTLY OR HAVE YOU EVER HAD ANY PROBLEMS IN THE FOLLOWING AREAS? IF YOU ANSWER **YES** TO ANY OF THE FOLLOWING OR HAVE A CONDITION NOT LISTED, PLEASE EXPLAIN IN THE MARGIN BELOW THE YES AND NO.*

EYES	YES	NO
LOSS OF VISION		
BLURRED VISION		
DISTORTED VISION/HALOS		
LOSS OF SIDE VISION		
DOUBLLE VISION		
DRYNESS		
MUCOUS DISCHARGE		
REDNESS		
SANDY OR GRITTY FEELING		
ITCHING		
BURNING		
FOREIGN BODY SENSATION		
EXCESS TEARING/WATERING		
GLARE/LIGHT SENSITIVITY		
EYE PAIN OR SORENESS		
CHRONIC INFECTION OF EYE OR LID		
STYES OR CHALAZION		
FLASHES/FLOATERS		
TIRED EYES		
OTHER:		
ENDOCRINE	**YES**	**NO**
ELEVATED CHOLESTEROL		
THYROID/OTHER GLANDS		
DIABETES TYPE I		
DIABETES TYPE II		
OTHER:		
EARS, NOSE, MOUTH, THROAT	**YES**	**NO**
ALLERGIES/HAY FEVER		
SINUS CONGESTION		
RUNNY NOSE, POST-NASAL DROP		
CHRONIC COUGH		
DRY THROAT/MOUTH		
OTHER:		
CONSTITUTIONAL	**YES**	**NO**
FEVER, WEIGHT, LOSS/GAIN		
SKIN	**YES**	**NO**
CANCER		
OTHER:		
NEUROLOGICAL	**YES**	**NO**
HEADACHES		
MIGRAINES		
SEIZURES		
OTHER:		

CANCER	YES	NO
TYPES:		
RESPIRATORY	**YES**	**NO**
ASTHMA		
CHRONIC BRONCHITIS		
EMPHYSEMA		
OTHER:		
VASCULAR/CARDIOVASCULAR	**YES**	**NO**
CHEST PAIN		
HIGH BLOOD PRESSURE		
VASCULAR DISEASE		
HEART ATTACK		
ARTIAL FIB/IRREGULAR HEART BEAT		
CORONARY BYPASS		
CARDIAC STENTS		
STROKE		
GASTROINTESTINAL	**YES**	**NO**
DIARRHEA		
CONSTIPATION		
STOMACH ULCER		
GASTROESOPHAGEAL REFLUX (GERD)		
OTHER:		
GENITOURINARY	**YES**	**NO**
GENITALS/KIDNEY BLADDER		
PROSTATE		
OTHER:		
BONES/JOINTS/MUSCLES	**YES**	**NO**
RHEUMATOID OR INFLAMMATORY ARTHRITIS		
DEGENERATIVE OR OSTEOARTHRITIS		
GOUT		
OTHER:		
LYMPHATIC/HEMATOLOGICAL	**YES**	**NO**
ANEMIA		
BLEEDING PROBLEMS		
OTHER:		
AUTOIMMUNE	**YES**	**NO**
LUPUS		
SJOGREN'S SYNDROME		
OTHER:		
PSYCHIATRIC	**YES**	**NO**
DEPRESSION		
ANXIETY DISORDER		
SCHIZOPHRENIA OR BIPOLAR		
OTHER:		

SOCIAL HISTORY

THIS INFORMATION IS KEPT STRICTLY CONFIDENTIAL. HOWEVER, YOU MAY DICUSS THIS PORTION DIRECTLY WITH THE DOCTOR ID YOU PREFER

DO YOU DRIVE? _____NO _____YES

IF YES, DO YOU HAVE VISUAL DIFFICULTY WHEN DRIVING? _____NO _____YES

IF YES, PLEASE DESCRIBE: _____

DO YOU USE TOBACCO PRODUCTS? _____NO _____YES

IF YES, TYPE/AMOUNT/HOW LONG: _____

DO YOU DRINK ALCOHOL? _____NO _____YES

IF YES, TYPE/AMOUNT/HOW LONG: _____

DO YOU USE ILLEGAL DRUGS? _____NO _____YES

IF YES, TYPE/AMOUNT/HOW LONG: _____

HAVE YOU EVER BEEN EXPOSED TO OR INFECTED WITH:

GONORRHEA_____HEPATITIS_____HIV_____AIDS_____SYPHILIS_____WILL DISCUSS WITH DOCTOR

I UNDERSTAND THAT I MAY BE DILATED DURING MY OFFICE VISIT. IF I FEEL THAT MY VISION HAS BEEN IMPAIRED. I WILL MAKE OTHER ARRANGEMENT FOR TRANSPOTATION AFTER DILATION.

_____ (PATIENT'S SIGNATURE) _____ (DATE)

_____ (DOCTOR'S SIGNATURE) _____ (DATE)