Chicago Glaucoma Consultants

Patient Registration Form

PLEASE PRINT AND COMPLETE ALL ENTRIES

PATIENT NAME (LAST, FIRST, MIDDLE INITIAL)	ADDRESS		
CITY, STATE & ZIP CODE	HOME PHONE	CELL PHONE	Email:
Patient SSN# - -	Preferred Method of Contact ❑ Cell # ❑ Email ❑ Text	D.O.B ____/_____/_____	MARITAL STATUS ❑ Single ❑ Married ❑ Other_____	SEX ❑ Male ❑ Female
PATIENT EMPLOYER NAME	PATIENT EMPLOYER ADDRESS (STREET ADDRESS - CITY - STATE - ZIP)	EMPLOYER PHONE	

INSURED/RESPONSIBLE PARTY INFORMATION

RELATION TO PATIENT: ❑Self ❑Parent ❑Guardian ❑ Spouse

NAME (LAST, FIRST, MIDDLE INITIAL)	ADDRESS (if different from patient)			
HOME PHONE	WORK PHONE	SSN	BIRTH DATE	EMPLOYER

INSURANCE INFORMATION

PRIMARY INSURANCE NAME	ADDRESS (STREET - CITY - STATE - ZIP)		PHONE
GROUP NUMBER	ID NUMBER	EMPLOYER	EMPLOYER PHONE
SECONDARY INSURANCE NAME	ADDRESS (STREET - CITY - STATE - ZIP)		PHONE
GROUP NUMBER	ID NUMBER	EMPLOYER	EMPLOYER PHONE

Referred by: ❑ Website ❑ Friend/Family : _____	
PRIMARY DOCTOR/FAMILY DOCTOR	REFERRING DOCTOR
IN CASE OF EMERGENCY CONTACT	RELATIONSHIP / PHONE NUMBER

FINANCIAL ASSIGNMENT AND RELEASE:

Chicago Glaucoma Consultants and CGC Eye Center offer convenient payment options while maintaining the highest standard of comprehensive eye care. Please read the following information regarding our policies and indicate the appropriate section in regards to your insurance.

Patients with Medicare or PPO: We accept and submit to most insurances. It is your responsibility to pay and **deductible amount. Co-pays** (if applicable are due at the time of service). Please note: Medicare and most secondaries do NOT pay for eye refractions. This cost is your responsibility and we ask that you pay at the time of service.

Patients with HMO insurance: We accept and submit to many HMO insurance providers. It is required that you have a valid referral submitted to your insurance by your **primary care physician** with the referral number every time you see our Doctors. If you do not have a valid referral, full payment is the responsibility of the patient and due at the time of service. Please speak to a member of your billing department if you have any further questions. **Copay is due at the time of service.**

Patients with Vision Plan: We strongly suggest that you contact your provider prior to your first visit to ensure that we are within your specific plan. We will also pre-authorize your coverage prior to being seen. Please be advised that vision plans DO NOT cover medical conditions of the eye; only for routine eye care. **Copay is due at the time of service.**

Refraction Charge is $50 (Prescription for eye glasses) Please be aware that as of 1992, a refraction test is a separate billed procedure for your exam.

Patients not submitting to insurance: We ask that you **pay at the time of service.** As a courtesy to our patients, we offer a discounted rate when payment is received in full at the time of service. Payment options are only considered when discussed prior to treatment. For your convenience, we accept cash, check, money orders and most credit cards.

***Late payments: Balances beyond 60 days outstanding are subject to a 10% late-pay-fee for every 30 day cycle thereafter.**
***Returned Checks: There is a $35 book-keeping charge for any and every returned check.**

SIGNATURE (Patient or, if minor Signature of parent or guardian)	DATE

HIPPA Authorization to release health information to:

Name(s)	**ADDRESS**		
CITY, STATE	**ZIP**	**HOME PHONE**	**DAYTIME PHONE**
DATES OF SERVICE **FROM:** **TO:**	**AUTHORIZATION EXPIRES (UNLESS OTHERWISE NOTED THIS AUTHORIZATION WILL REMAIN IN EFFECT ONE YEAR FROM THE DATE SIGNED)** ❑ **NEVER** **DATE:**		

I understand that:

•	Once "this facility" discloses my health information by my request, it cannot guarantee that Recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state laws governing the use and disclosure of my health information.
•	I may make a request in writing at any time to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR (164.524).
•	my records are protected and cannot be disclosed without written permission
•	This Authorization will remain in effect for one year or I provide a written notice of revocation to the Medical Record Department.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	**DATE**	**EMAIL**
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT	**SIGNATURE OF WITNESS (Optional):**	

PATIENT OCULAR HISTORY

Please check the following symptoms you have or have had in the past with a brief description

❑ Blurred vision	❑ Eye Infection	❑ Floaters	❑ Sensitive to Light	Have you had any eye surgeries?
❑ Cataracts	❑ Eye Injury	❑ Glaucoma	❑ Retinal Disease	❑ **Yes** ❑ **NO**
❑ Crossed Eyes	❑ Dry eyes	❑ Headaches	❑ Seeing Halos	When? _____
❑ Double Vision	❑ Eye Pain	❑ Loss of Vision	❑ Other: _____	❑ **Right eye** ❑ **Left Eye** ❑ **Both**
❑ Flashes of Lights / Floaters	❑ Retinal Detachment	❑ Blindness		

FAMILY HISTORY – Please indicate if any of your immediate relatives have had any of the following by placing an X in the appropriate box.

Conditions	**MOTHER**	**FATHER**	**SIBLING (Brother/Sister)**
Glaucoma			
Blindness			
Corneal Disorders			
Macular Degeneration			
Retinal Disease			
Stroke			

PATIENT MEDICAL HISTORY

Allergies:

Preferred Pharmacy
(name/number/location)

FAMILY HISTORY – Please indicate if any of your immediate relatives have had any of the following by placing an X in the appropriate box.

	MOTHER	FATHER	SIBLING (Brother/Sister)
Anesthesia Problems			
Arthritis			
Cancer			
Diabetes			
Heart Problems			
Hypertension			
Stroke			
Thyroid Disorder			

SOCIAL HISTORY

Marital status: □ Single □ Married □ Divorced □ Widowed □ Separated
Occupation: _____ □ Retired □ Disabled (reason _____)
□ **Yes** □ **No -** Do you drink alcohol? □ Daily □ Weekly □ Infrequently □ Recovering Alcoholic
□ **Yes** □ **No -** Do you use tobacco? □ Former Smoker □ Smoke (___ packs per day) □ Chew

Surgical History: Please list any hospitalizations, surgeries, fractures or major illnesses you have had.

TYPE OF SURGERY	YEAR or DATE	DOCTOR	LOCATION

Medical History: Have you ever had any of the following?

- ❑ NONE of the problems listed
- ❑ allergies
- ❑ anemia
- ❑ arthritis
- ❑ asthma
- ❑ atrial fibrillation
- ❑ bleeding problems
- ❑ BPH- Prostate Problems
- ❑ coronary artery disease
- ❑ cancer: _____
- ❑ cardiac arrest
- ❑ celiac disease
- ❑ chest pain
- ❑ CHF congestive heart failure
- ❑ chronic fatigue syndrome
- ❑ depression
- ❑ diabetes
- ❑ drug/alcohol abuse
- ❑ erectile dysfunction
- ❑ fibromyalgia
- ❑ GERD
- ❑ heart disease
- ❑ high cholesterol
- ❑ high blood pressure
- ❑ hypothyroidism
- ❑ Insomnia
- ❑ irritable bowel syndrome
- ❑ menopause
- ❑ migraines/headaches
- ❑ neuropathy
- ❑ onychomycosis
- ❑ osteoporosis
- ❑ organ injury
- ❑ pulmonary embolism/blood clot in legs
- ❑ seizure disorders
- ❑ shortness of breath
- ❑ sinus conditions
- ❑ stroke
- ❑ syndrome X
- ❑ tremors
- ❑ wheat allergy

Other: _____

Medications: List any medications you are currently taking (please include over the counter medications):
PLEASE PRINT LEGIBLY – NO CURSIVE PLEASE

MEDICATION	DOSAGE	PRESCRIBING DOCTOR