Chirag S. Shah, M.D. & Angana Shah, M.D.

Ophthalmologist

CONFIDENTIAL

Patients under 18 must be accompanied by an adult

PATIENT REGISTRATION

Last Name: _____ First Name: _____ MI: _____

Address: _____ Apt #: _____ City: _____

State: _____ Zip Code: _____ Home Phone: _____

Birth Date: _____ Age: _____ Sex: M Cell Phone: _____

Marital Status: Single Social Security #: _____ - _____ - _____

If a minor, Parent/Guardian Name: _____ Phone: _____

Employer: _____ Work Phone: _____

Nearest Relative's Name: _____ Relative's Phone:_____

Referred By: _____ Phone:_____

Medical Doctor: _____ Phone:_____

INSURANCE INFORMATION

Please present all insurance ID cards and referrals to the receptionist, without it services cannot be rendered according to the insurance law.

Primary Insurance Name: _____

Policy Holder's Name: _____ Birth Date: _____

Relationship: _____

Policy #: _____ Group #: _____

Secondary Insurance Name: _____

Policy Holder's Name: _____ Birth Date: _____

Relationship: _____

Policy #: _____ Group #: _____

1. I am responsible to provide the referral, where required.
2. I am responsible to provide the payment and co-payment when services are rendered.
3. I understand that I am financially responsible for any balance not covered by my insurance, such as deductible, co-insurance and co-payment.
4. I authorize the release of any medical information necessary to process an insurance claim.
5. I will immediately notify your office of any change of address, phone number and insurance information.
6. I am responsible to inform you about the complete benefits provided by my insurance.

Patient / Parent / Guardian Signature: _____ Date: _____

Relationship: _____

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Patient Name: _____ Date: _____ Height: _____ Weight: _____

Are you Pregnant? ○ Yes ○ No

Do you have a prescription drug plan? ○ Yes ○ No Pharmacy Phone: _____

Please list any drug allergies: _____

Please list any other allergies: _____

Please list present medications: _____

Chief Complaint: What kind of problem are you seeing Dr. Shah for? _____

_____

How long have you had this condition? _____

What medications or antibiotics have you tried so far? _____

MEDICAL HISTORY

Illnesses: 1. _____ 2. _____ 3. _____

Hospitalizations: 1. _____ 2. _____ 3. _____

Operations: 1. _____ 2. _____ 3. _____

Injuries: 1. _____ 2. _____ 3. _____

SOCIAL HISTORY

Smoke: ○ No ○ Yes _____ packs per day Caffeine: ○ No ○ Yes _____ cups per day

Alcohol: ○ No ○ Yes _____ type & amount Diet: _____

FAMILY HISTORY

(check all that apply)

☐ High Blood Pressure ☐ Diabetes ☐ Glaucoma ☐ Asthma ☐ Thyroid Disease ☐ Stroke

☐ Autoimmune Disease ☐ Eye Allergies ☐ Macular Degeneration ☐ Headaches ☐ Bleeding Problem ☐ Cancer

REVIEW OF SYSTEMS

Blurred Vision: ☐ Near ☐ Far ☐ Both

Eye: ☐ Pain ☐ Redness ☐ Headaches/Pressure

Double Vision: ☐ Lazy Eye

Allergy/Infection: ☐ Itching ☐ Burning ☐ Tearing ☐ Discharge

GENERAL

☐ High Blood Pressure	☐ Tuberculosis	☐ Kidney Disease	☐ Weight Loss or Gain	☐ Angina/Chest Pain
☐ Asthma	☐ Kidney Stones	☐ Heartburn	☐ Heart Attack	☐ Lung Disease
☐ Prostrate Problems	☐ Reflux	☐ Heart Failure	☐ Emphysema	☐ Difficulty Urinating
☐ Ulcers	☐ Liver Disease	☐ Shortness of Breathe	☐ Abnormal Heartbeat	☐ Diarrhea
☐ Lyme Disease	☐ Loss of Vision	☐ Anemia	☐ Stroke	☐ Eczema
☐ Constipation	☐ Diabetes	☐ Glaucoma	☐ Bleeding Problems	☐ Cancer
☐ Psoriasis	☐ Colitis	☐ Anxiety	☐ Eye Disease	☐ Easy Bruising
☐ Paralysis	☐ Rashes			

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CONSENT AGREEMENT

I, _____ understand that as part of my healthcare, Dr. Shah's office originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care of treatment. I understand that this information serves a:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third party, payer can verify that services billed were actually provided, and
- A tool for routine healthcare Operations, such as assessing quality, and renewing the competence of healthcare professionals.

I understand and I have been provided with a Notice of Health Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices, and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations; and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken in reliance thereon.

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

_____

_____

_____

_____

- ○ I fully understand and accept the terms of this consent.
- ○ I fully understand and decline the terms of this consent.

Patient / Parent / Guardian Signature: _____

Date: _____