Welcome To Our Practice

Patient Registration

(Please print all information)

Date: ____________________________

About the patient:

Patient's Last Name ________________________ **First** __________________ **M.I.** _____
Address ____
City ______________________________________ **State** ___________ **Zip** ___________
Date of Birth ______________________________ **Age** ____________ **Sex** ___**M** ___**F**
Social Security # ___________________________ **Cell Phone #** ____________________
Home Phone ________________________________ **E-mail** __________________________
Family Physician ____________________________ **Telephone** _______________________
Address ____
Eye Doctor _________________________________ **Telephone** _______________________
Address ____

Patient's Employer ____
Work Address ____
Work Phone _______________________________
Occupation _________________________________ **Full / Part Time** ______ **Student** _____
Is your condition or injury work related? No ___ **Yes** ___ **Date of injury** __________

If the patient is a minor:

Mothers Name ________________________
DOB ______ **Social Security #** __________
Address If Different:
____
____
Home phone __________________________
Employer _____________________________
Address ______________________________
Work Phone ___________________________

Fathers Name _________________________
DOB ______ **Social Security** ___________
Address if Differrent:
____
____
Home Phone __________________________
Employer _____________________________
Address ______________________________
Work Phone ___________________________

Person Responsible for Payment (If patient is a minor, parent or guardian)

The person who requests treatment is responsible for all fees for services rendered.

Name ____________________________ **Relationship** ______________________________

Primary Insurance Information (we would like to photocopy your card).

Name of Insurance Company ____
ID or Policy Number ____
Group Number or Plan Number ____
Address to send claim forms ____
City _________________________________ **State** ___________ **Zip** ___________
Subscriber's name __________________________ **DOB** _________________________
Social Security Number _____________________________
Patient's Relationship to the Subscriber _____ **Self** _____ **Spouse** _____ **Child** _____ **Other**

Secondary Insurance Information (we would like to photocopy your card).

Name of Insurance Company ____________________
Telephone Number ____________________
Group Number or Plan number ____________________
Address to send claim forms ____________________
City ____________________ **State** __________ **Zip** __________
Subscriber's name ____________________ **DOB** ____________________
Patient's Relationship to the Subscriber _____ **Self** _____ **Spouse** _____ **Child** _____ **Other**
Social Security Number ____________________

How did you learn about Dr. Wasserman (Please check all that apply)
____**Trenton Thunder**____________________
____**Radio Which Station**____________
____**Mall** ____________________
____**Google**____________
____**TV** ____________
____**Referred by Doctor** _____**Referred by someone who had LASIK**
____**Referred by a Family Member**____**Other**__________________

Please include the name of the person who referred you. We want to be sure to thank them. The best compliment any patient can give us is to refer their friends and family.

Name____________________
Relationship to Patient________________
Address____________________
City__________________**State**_________**Zip**_________

In case of Emergency

Please notify (family member or friend not living at your residence).
Name ____________________
Relationship ____________________ Phone ____________________

Private Insurance Authorization For Assignment of Benefits and Release of Information

I hereby authorize and direct payment of my medical benefits to Barry N. Wasserman, M.D., LLC, for any serviced furnished to me by the physicians. I understand that I am financially responsible for payment of any services for supplies that are deemed not medically necessary or non-covered by my insurance company. This includes refractions, contact lens examinations, and supplies. It is my responsibility to notify this office of any charge in my insurance plan before I visit. I further understand that I am responsible for charges incurred when my insurance coverage has been changed or terminated. I also authorize my insurance company to release any information required to process claims of benefits.

____________________ ____________________
Patient (or responsible party) Signature Date

Medicare Lifetime Signature on File

I request payment of authorized MEDICARE benefits be made either to me or on my behalf to Barry N. Wasserman, M.D.,, LLC, for any services furnished to me by the physicians. I authorize any holder of medical information to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

____________________ ____________________
Patient (or responsible party) Signature Date

Ears, nose, mouth and Throat	Yes	No	**Ear, nose, mouth and throat cont**	Yes	No
Sinus Congestion			Psychiatric depression, anxiety		
Runny nose/post nasal drip			**Family History**		
Chronic cough			Blindness		
Dry or sore throat/mouth			Cataract		
Respiratory:shortness of breath			Glaucoma		
Cardiovascular heart failure/heart attack			Macular degeneration		
Irregular heart beat			Retinal detachment		
Gastrointestinal			Arthritis		
Ulcers, heartburn			Cancer		
Urinary pain or discomfort			Diabetes		
Musculoskeletal			Heart Disease		
Skin rashes, dryness, moles, cancer			High blood pressure		
Neurological numbness, weakness			Kidney disease		
Migraine headaches			Lupus		
Stroke			Sjogrens'disease		
Endocrine heat or cold intolerance			Stroke		
Bleeding/bruising			Thyroid disease		
Allergic/immunologic/HIV or AIDS			Tuberculosis		
Allergy symptoms sneezing, itching			Other		

Please explain all "Yes" answers here:____________________________________

Social History

Current occupation or retired from:__________________________________
Do you drive: Yes No
Difficulty with Driving Yes No, If yes, please explain______________________
Problems with night vision Yes No If yes, please explain____________________
Do you drink alcohol Yes No If yes, number or drinks per week________________
Do you smoke Yes No If yes number of packs per day______________________
Have you ever had a blood transfusion Yes No If yes please explain:_____________
Have you ever been treated or exposed to an infectious disease (circle) Hepatitis A/ B / C HIV or AIDS / Syphillis

Medical History Questionnaire

Name:____ Date:____________________
Do you wear glasses (circle) **YES** or **NO** If yes, how long have you had the current pair?______
Do you wear contacts (circle) **YES** or **NO** If yes, how long have you had the current pair?______
Do you have an interest in refractive surgery, LASIK (corrects nearsightedness, farsightedness and astigmatism) **YES** or **NO**
List any medications, including eye drops, that you take:________________________________

List any vitamins, nutritional supplements or herbs that you take:________________________

Do you have (circle) DIABETES / HEART DISEASE / HIGH BLOOD PRESSURE?
List all major illnesses and injuries (Date)____

List surgeries you have had:____

Allergies to any medications or foods: Sulfa Drugs / Fluorescein Dye-Iodine-Penicillin
If others, please list:____
Do you have any cultural/language/visual/auditory and religious factors affecting your care? **Yes** or **No**
Do you have an advance directive on file (e.g. living will or durable power of attorney for health care) if you are 18 years or older? **Yes** or **NO**

Do you currently have any problems in the following areas? Provide additional information for any "Yes" answer below.

Constitutional Symptoms	Yes	No	**Eyes con't**	Yes	No
Fever			Sandy or gritty feeling		
Weight Loss			Itching		
Fatigue			Burning		
Eyes			Foreign body sensation		
Loss of vision			Excess tearing/watering		
Blurred vision			Occasional tearing		
Loss of side vision			Glare/light sensitive		
Double vision			Eye pain or soreness		
Dryness			Chronic infection of eye or lid		
Mucous discharge			Sty or Chalazion		
Redness			Fluctuating visual acuity		

Please explain all "Yes" answers here:____

Physician signature__________________________ Date______________________