

Dr. Karen Koumjian – Watertown Eye Associates

Eye Care Registration and History

Welcome to our Office

PATIENT INFORMATION

Date _____

Patient _____

Address _____

City _____

State _____ Zip _____

Sex: M F Birth Date _____

Single Married Other

Patient SS# _____

Occupation _____

Spouse's Name _____

Whom may we thank for referring you? _____

INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? Yes No

Subscriber Name _____

SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to

Dr. _____ all insurance benefits.

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions

Responsible Party Signature _____

Relationship _____ Date _____

PHONE NUMBERS

Home _____ Work _____ Ext. _____ Cell Phone _____
Personal Email _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone _____ Work Phone _____

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. _____ for any services furnished me by that doctor. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Signature of Beneficiary _____ Date _____

Please present your insurance card to the receptionist.
Copayments are payable at the time of visits.

EYE HEALTH HISTORY

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Physician's Name _____

Date of last visit _____

Date of last eye exam _____

Name of eye doctor _____

Do you wear glasses? Yes No

All the time Occasionally

Reading Driving TV

Do you wear contacts? Yes No

Type _____ Hrs/Day _____

Describe any problems you have with your contacts _____

- | | | | |
|----------------------------|--|--------------------------|--|
| Bloodshot Eyes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Floaters or Spots | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blurred Vision – Distance | <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blurred Vision – Near | <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Burning Eyes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Itching Eyes | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cataracts | <input type="checkbox"/> Yes <input type="checkbox"/> No | Light Sensitive | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Color Vision, Poor | <input type="checkbox"/> Yes <input type="checkbox"/> No | Loss of Vision | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Crossed Eyes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Migraine Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Discharge from Eyes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Night Vision, Poor | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Dizzy Spells | <input type="checkbox"/> Yes <input type="checkbox"/> No | Red Eyes | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Double Vision | <input type="checkbox"/> Yes <input type="checkbox"/> No | Seeing Halos | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Dry Eyes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Seeing Flashes | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Eye Infection | <input type="checkbox"/> Yes <input type="checkbox"/> No | Temporary Loss of Vision | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Eye Injury | <input type="checkbox"/> Yes <input type="checkbox"/> No | Twitching Eyelid | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Eye Strain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Vision Poor | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Fainting Spells, Blackouts | <input type="checkbox"/> Yes <input type="checkbox"/> No | Watering Eyes | <input type="checkbox"/> Yes <input type="checkbox"/> No |

HEALTH HISTORY

Place a mark on "Yes" or "No" to indicate if you have had any of the following. Also place a mark to indicate if a blood relative has had any of the following problems.

- | | Yourself | Family Members | | Yourself | Family Members |
|------------------------|--|--|---------------------|--|--|
| AIDS/HIV | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valve | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | Lazy Eye | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | Lupus | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | Migraine Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blindness | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | Poor Color Vision | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cataracts | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | Retinal Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Emphysema | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shingles | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | Skin Conditions | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Eye Surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Conditions | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hay Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Condition | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | Turned Eye | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hepatitis (Type _____) | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |

MEDICATIONS

List medications you are currently taking, including eye drops:

Pharmacy Name _____

Phone _____

ALLERGIES

List your allergies to medications or other substances:

