PATIENT REGISTRATION FORM

First Name	MI	Last Name	Age	Date of Birth	Sex
Home Address		City	State	Zip Code	
Home Phone		Mobile Phone	Social Security No.		
Spouse Name	DOB	Phone Number	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed		
Employer Name / Company		Position	Work Phone Number		
Financially Responsible Person ☐ Patient ☐ Spouse ☐ Parent ☐ Other		Name (**if different from patient**)	Date of Birth		
Responsible Person's Address		Phone Number			
Email Address:					

Is patient residing in a **Skilled Nursing Facility**? Yes No	Address	Facility Phone Number

Please Choose Ethnicity:

☐ Hispanic/ Latino

☐ Non- Hispanic/ Latino

Please Choose Race

☐ Caucasian ☐ African American

☐ Asian ☐ Pacific Islander

☐ Native American

In order for us to provide you with the best care, we may need to share medical information with physicians / facilities that you list below. You may also verbally update this list as needed. This order shall remain in effect until revoked by the patient.

Primary Care Doctor	Facility Name	Phone Number
Eye Doctor	Facility Name	Phone Number
Other Physicians	Facility Name	Phone Number

Please list below Emergency Contact Personnel with whom we may leave messages to make, cancel and re-schedule appointments as well **general** billing information.

Name	Relationship	Home Phone	Mobile Phone
Name	Relationship	Home Phone	Mobile Phone

Are there ways or persons with whom we may NOT leave general information?

Please list below.

____

____

____

____ ____/____/____

Patient Signature Date

CUMBERLAND VALLEY RETINA CONSULTANTS

Medical Questionnaire

Please Complete **ALL** Sections

Eye Medical History	Yes	No	What year?
Eye Injury			
Cataracts			
Macular Degeneration			
Retinal Detachment/ Holes			
Diabetic Retinopathy			
Corneal Dystrophy			
Lattice Degeneration			
Dry Eye Syndrome			
Glaucoma			
Infection (Corneal Ulcer)			
Uveitis / Iritis			
Crossed- Eyes/ Lazy Eye			
Color Blindness			
Macular Pucker			

Name: ______________________________

Birthdate: ____/____/____

Allergies/ Reactions: ______________________

____

____

Have you ever had a blood transfusion? Yes No

Do you drink alcohol? Yes No

If yes: Occasional 1/day 2-3/day 4+/day

Do you smoke? Yes No

If yes: Occasional ½ pack/day 1pack/day 1+pack/day

Are there any other details about your Eye Medical History we should know about?

____

____

____

Eye Procedures	Which Eye?	What Year?	Physician	Reason
Laser				
Cataract				
Refractive (Lasik)				
Vitrectomy				
Injection				
Other				

Past Medical History:

Lung Disease	Yes	No
Kidney Stones		
Diabetes Type I		
Diabetes Type II		
High Blood Pressure		
Heart Disease		
Stroke		
Cancer (What type of Cancer?)		
Thyroid Disease		
Arthritis		
Headaches		
Gout		
STD		
Skin Disease		
Gastrointestinal		
Blood Disorders		
Multiple Sclerosis		

Family History:

Blindness	Yes	No	Who?
Cataract			
Glaucoma			
Diabetes			
Retinal Detachment			
Hypertension			
Heart Disease			
Stroke			
Cancer			
Thyroid Disease			
Arthritis			
Macular Degeneration			
Color Blindness			
Strabismus (Crossed Eyes)			
Multiple Sclerosis			

Are there any other details about your Past Medical History or Family Medical History that you would like to share?

____

____

____

____

__________________________ ____/____/____

Patient Signature Date

CUMBERLAND VALLEY RETINA CONSULTANTS

MEDICATION LIST

Name: ______________________________ DOB: ____/____/____ Date: ____/____/____

Please list your prescription below. If you already have a medication list printed, we can make a copy at the time of your appointment.

Medication	Dosage (Total Milligrams)	How many times daily?	When do you take it? (AM, PM, After meals?)	Prescribing Physician	Reason for taking this

Please list below any over-the-counter medications.

This includes aspirin, herbal remedies and multivitamins.

Medication	Dosage (Total Milligrams)	How many times daily?	When do you take it? (AM, PM, After meals?)	Reason for taking this

PLEASE COMPLETE ALL SECTIONS ON THE FORM

OR BRING ALL OR YOUR MEDICATIONS WITH DOSAGE INSTRUCTIONS

Information Regarding Dilating Eye Drops

Dilating drops are used to enlarge the pupils of the eye in order for our physicians to get a clearer view of the back of your eyes.

As a result of the drops, your vision may be blurred for a length of time. This time period varies from patient to patient and may be accompanied by sensitivity to bright lights. **It is not possible for your ophthalmologist to predict how your vision may be affected.**

Due to the possibility of altered vision immediately following your appointment, we strongly suggest that you make arrangements **not** to drive yourself.

I hereby authorize the physicians or clinicians to administer dilating eye drops as deemed appropriate. I understand that these eye drops are necessary in order to diagnose my condition.

____ ____/____/____

Patient (or person authorized to sign for patient) **Date**

ACKNOWLEDGEMENT: RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient ID # ________

I have been provided an opportunity to review Cumberland Valley Retina Consultant's Notice of Privacy Practices effective September 23rd, 2013.

I understand that I may request a printed copy at any time.

Name (Print): ________________________________

Signature: ________________________________
Date: ____/____/_____

I am a parent or legal guardian of________________________________.
I have been provided an opportunity to review Cumberland Valley Retina Consultant's Notice of Privacy Practices effective September 23, 2013.

I understand that I may request a printed copy at any time.

Name (Print): ________________________________

Relationship to Patient: ☐ Parent ☐ Legal Guardian

Signature: ________________________________
Date: ____/____/_____

Patient ID # __________

Financial Policy Statement

Welcome to Cumberland Valley Retina Consultants, P.C. We are pleased that you have chosen our facility for your medical care. Please carefully read and sign the following policy.

Our office will gladly file for all reimbursable services to primary, secondary, and tertiary insurances. **Please be aware that you are responsible for all deductibles, copays, coinsurances and non-covered service amounts.** As the insured, we expect you to know your coverage, benefits, and responsibilities. Understand that while we file your claim with the insurance company, our relationship is with you and **not** your insurance carrier.

It is the patient's / responsible party's responsibility to provide all necessary referrals, authorizations, and current, accurate billing information. **Failure to do so will result in charges for services becoming the sole responsibility of the patient / responsible party.**

I, ____, understand and accept the Financial Policy written above. I hereby authorize Cumberland Valley Retina Consultants, P.C., to apply for benefits on my behalf for services rendered. I verify that all information provided at the time of service is correct. I authorize the release of information, including medical information necessary to process my insurance claim, and authorize the payment of medical/surgical benefits to Cumberland Valley Retina Consultants. I permit a copy of this authorization to be used in place of the original. I understand that I may revoke this authorization at any time in writing.

____   _____/_____/_____

Patient Signature   **Date**