THE HUGHES EYE GROUP - REGISTRATION FORM

PATIENT INFORMATION

Patient Name (Last, First, Middle Initial): _____

Address (Street, City, State, and Zip): _____

Home Phone #: _____ **Cell Phone #: _____**

Social Security #: _____ **Date of Birth: _____** **Sex:_____**

Referring Doctor: _____ **Medical Doctor: _____**

Emergency Contact Name: _____ **Relationship: _____Phone #:_____**

E-Mail Address: _____ **Employer: _____**

Patient Preferred Contact Method (check one): ____ Home Phone ____ Cell Phone ____ Email ____ Regular Mail

SPOUSE / GUARDIAN / NEXT OF KIN INFORMATION

Only indicated if the Patient is NOT the Responsible Party or Insured

Spouse or Guardian (Last, First, Middle Initial) _____

Relationship to Patient: ____Spouse ____Guardian ____Parent ____Other: _____

Address (Street, City, State, & Zip): _____

THE HUGHES EYE GROUP - FINANCIAL POLICY

We are committed to providing you with the highest level of service and quality of care. If you have medical insurance, we strive to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our Financial Policy. Ultimately, any and all financial liability rests with the patient and their family.

Our office participates with most major medical insurance plans. We provide MEDICAL and SURGICAL services to our eye care patients. We DO NOT participate in ANY VISION PLANS. If you have a managed care plan that requires a referral to see a specialist, you must obtain a referral for your visit in our office to be covered under your medical insurance. If you do not have the proper referral and still wish to be seen, you are required to pay for your visit prior to your examination.

PATIENT RESPONSIBILITY: It is **YOUR** responsibility to:

- Contact your insurance company to obtain co-payment/co-insurance/deductible information and to verify that our physicians are participating, IN-NETWORK providers with your insurance
- Provide our practice with correct and current insurance information on or before the date of service
- Bring all current insurance cards to every visit
- Obtain your insurance referrals and understand your insurance policy

Co-payments, Co-insurance and Deductibles are collected at the time of service as REQUIRED by our contract with your insurance company. We accept cash, personal checks, MasterCard, Visa, Discover, and American Express. Co-payments are charged at the "Specialist" office rate. If you arrive unprepared to pay these required fees, we will need to reschedule your appointment. We do not accept postdated checks, and we do not accept attorney letters promising payment after settlement of accident and/or injury claims.

Self-Pay Patients: (Patients who have no form of medical insurance)
Self-Pay patients are required to pay fees in full at the time of service prior to seeing the doctor. Fees are based on the cost of a basic exam and testing as indicated by the doctor. Full payment is required prior to all surgical procedures. We do not accept postdated checks, and we do not accept attorney letters promising payment after settlement of accident and/or injury claims.

HUGHES EYE GROUP MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Preferred/Nickname: _____ Date of Birth: ____/____/_____

Primary Care Physician: _____ Referring /Specialty Dr:_____

Pharmacy:_____ Pharmacy Location (City/Street):_____

Primary Care Doctor: _____

Race: □ American Indian or Alaska Native □ Asian □ African American
□ Native Hawaiian or Other Pacific Islander □ White

Ethnicity: □ Hispanic □ Not Hispanic

Preferred Language: □ English □ Spanish □ Other: _____

Allergies to Medications	Reaction	Severity
_____	_____	mild / moderate / severe
_____	_____	mild / moderate / severe
_____	_____	mild / moderate / severe

Problems with Anesthesia: □ No □ Yes, reaction:_____

Have you ever had the Pneumonia Vaccine (This is a required question by the Government): □ No □ Yes

Have you ever had a Fall? (This is a required question by the Government): □ No □ Yes

Past Ocular History: (Mark all that apply)

□ Overall Healthy
□ Amblyopia (Lazy eye)
□ Aphakia
□ Astigmatism
□ Cataracts
□ Diabetic Retinopathy
□ Dry Eyes
□ Glaucoma
□ Hyperopia (Far sighted)
□ Iritis
□ Keratoconus
□ Macular Degeneration
□ Myopia (Near sighted)
□ Optic Neuritis
□ Retinal Detachment
□ Trauma

Other_____

Ocular Surgeries: (Mark all that apply)

□ No prior ocular surgery
□ Blepharoplasty
□ Cataract Surgery
□ Corneal Transplant
□ Foreign Body Removal
□ Retinal Laser Surgery
□ LASIK
□ PRK
□ Punctal Plugs
□ RK
□ Strabismus/ Muscle Surgery
□ Trabeculectomy (Glaucoma surgery)
□ Vitrectomy

Other_____

Current Eye Medications: (Please list)

_____

_____

Systemic Illnesses:

□ No history of illnesses
□ Anemia
□ Arthritis
□ Arrhythmia
□ Asthma
□ Bleeding Disorder
□ Cancer
□ Thyroid Disease
□ Congestive Heart Failure
□ COPD
□ Diabetes
□ Eczema
□ Fibromyalgia
□ Headache
□ Hearing Loss
□ Hepatitis
□ High Blood Pressure
□ High Cholesterol
□ HIV
□ Kidney Disease
□ Kidney Stones
□ Liver Disease
□ Lung Disease
□ Lupus
□ Migraine
□ Polymyalgia
□ Psychiatric Disorder
□ Skin Cancer
□ Stroke

Other_____

Ocular Significant Illnesses: (Mark all that apply)

□ Overall Healthy
□ AIDS
□ Diabetes
□ Rheumatoid Arthritis
□ Herpes
□ HIV Positive
□ Hypertension
□ Hypothyroidism
□ Lupus
□ Multiple Sclerosis
□ Sjogrens
□ Graves Disease
□ Hyperthyroidism

Other_____

Infections: (Mark all that apply)

□ Overall Healthy
□ Chicken Pox
□ Hepatitis A / B / C
□ Herpes Simplex
□ Herpes Zoster / Shingles
□ Histoplasmosis
□ HIV / AIDS
□ Meningitis
□ MRSA
□ Syphillis
□ Toxoplasmosis
□ Wound Infection

Other_____

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General Surgeries / Operations: (Please List)

_____
_____

Current Systemic Medications: (Please list below or bring a copy of pharmacy list)

_____
_____
_____
_____

Have you ever taken prostate medicines / alpha blockers?
Please circle: Flomax, Tamsulosin, Hytrin, Cardura, Saw Palmetto, Doxazosin, Terazosin, Uroxatral, Rapaflo

Family History (other than yourself): (please circle applicable family members) □ ***Unknown Family History***

□ Glaucoma	Parent / Sibling / Maternal Grandparent / Paternal Grandparent
□ Macular Degeneration	Parent / Sibling / Maternal Grandparent / Paternal Grandparent
□ Blindness	Parent / Sibling / Maternal Grandparent / Paternal Grandparent
□ Diabetes	Parent / Sibling / Maternal Grandparent / Paternal Grandparent
□ Cancer	Parent / Sibling / Maternal Grandparent / Paternal Grandparent
□ Heart Disease	Parent / Sibling / Maternal Grandparent / Paternal Grandparent
□ High Blood Pressure	Parent / Sibling / Maternal Grandparent / Paternal Grandparent

Social History: (Mark all that apply)

Smoking: □ *current every day smoker* □ *current some day smoker* □ *former smoker* □ *never smoked*

Alcohol Use: □ *Yes* □ *No* *If yes how much and how often?*_____

Recreational Drug Use: □ *Yes* □ *No* *If yes what and how often?*_____

Review of Systems: (Mark all that apply)

Eyes
- □ Previous Surgery
- □ Contact Lens
- □ Pain
- □ Double Vision
- □ Glaucoma
- □ Cataracts
- □ Macular Degeneration
- □ Dry Eyes
- □ Flashes
- □ Floaters

Ear, Nose, and Throat
- □ Hard of Hearing
- □ Ringing in Ears
- □ Vertigo

Cardiovascular
- □ Chest Pain
- □ Dizziness
- □ Fainting Spells
- □ Shortness of Breath
- □ Irregular Heart Beat
- □ Difficulty Lying Flat

Constitutional
- □ Fatigue / Weakness
- □ Fever
- □ Weight Gain / Loss

Respiratory
- □ Cough
- □ Congestion
- □ Wheezing
- □ Asthma

Gastrointestinal
- □ Heartburn
- □ Nausea / Vomiting
- □ Jaundice / Hepatitus

Genito-Urinary
- □ Pain / Difficulty
- □ Blood in Urine
- □ History of Kidney Stones
- □ History of STD's

Psychiatric
- □ Anxiety / Depression
- □ Mood Swings
- □ Difficulty Sleeping

Endocrine
- □ Increased Thirst
- □ Increased Hunger
- □ Increased Urination
- □ Increased Sweating
- □ Fingernail Changes

Blood / Lymphnodes
- □ Easy Bruising
- □ Gums Bleed Easy
- □ Prolonged Bleeding
- □ Heavy Aspirin Use

MusculoSkeletal
- □ Stiffness
- □ Arthritis
- □ Joint Pain / Swelling

Skin
- □ Rash / Sores
- □ Lesions
- □ Hives / Eczema

Neurological
- □ Seizures
- □ Weakness / Paralysis
- □ Numbness
- □ Tremors

Immunologic
- □ Hives
- □ Itching
- □ Runny Nose
- □ Sinus Pressure