

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 Eye 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)

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Overall Healthy | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Hyperopia (Far sighted) | <input type="checkbox"/> Myopia (Near sighted) |
| <input type="checkbox"/> Amblyopia (Lazy eye) | <input type="checkbox"/> Diabetic Retinopathy | <input type="checkbox"/> Iritis | <input type="checkbox"/> Optic Neuritis |
| <input type="checkbox"/> Aphakia | <input type="checkbox"/> Dry Eyes | <input type="checkbox"/> Keratoconus | <input type="checkbox"/> Retinal Detachment |
| <input type="checkbox"/> Astigmatism | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Trauma |

Other _____

Ocular Surgeries: (Mark all that apply)

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> No prior ocular surgery | <input type="checkbox"/> Foreign Body Removal | <input type="checkbox"/> Punctal Plugs | <input type="checkbox"/> Trabeculectomy |
| <input type="checkbox"/> Blepharoplasty | <input type="checkbox"/> Retinal Laser Surgery | <input type="checkbox"/> RK | (Glaucoma surgery) |
| <input type="checkbox"/> Cataract Surgery | <input type="checkbox"/> LASIK | <input type="checkbox"/> Strabismus/ Muscle Surgery | <input type="checkbox"/> Vitrectomy |
| <input type="checkbox"/> Corneal Transplant | <input type="checkbox"/> PRK | | |

Other _____

Current Eye Medications: (Please list)

Systemic Illnesses:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> No history of illnesses | <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> COPD | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Migraine |
| <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> Eczema | <input type="checkbox"/> HIV | <input type="checkbox"/> Polymyalgia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Psychiatric Disorder |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Headache | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Skin Cancer |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Thyroid Disease | | | |

Other _____

Ocular Significant Illnesses: (Mark all that apply)

- | | | | |
|---|---------------------------------------|---|--|
| <input type="checkbox"/> Overall Healthy | <input type="checkbox"/> Herpes | <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Sjogrens |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Lupus | <input type="checkbox"/> Graves Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Hyperthyroidism |
| <input type="checkbox"/> Rheumatoid Arthritis | | | |

Other _____

Infections: (Mark all that apply)

- | | | | |
|--|---|-------------------------------------|--|
| <input type="checkbox"/> Overall Healthy | <input type="checkbox"/> Herpes Simplex | <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Herpes Zoster / Shingles | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Toxoplasmosis |
| <input type="checkbox"/> Hepatitis A / B / C | <input type="checkbox"/> Histoplasmosis | <input type="checkbox"/> MRSA | <input type="checkbox"/> Wound Infection |

Other _____

Please continue on the back side of this page →

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

- | | |
|---|--|
| <input type="checkbox"/> Glaucoma | Parent / Sibling / Maternal Grandparent / Paternal Grandparent |
| <input type="checkbox"/> Macular Degeneration | Parent / Sibling / Maternal Grandparent / Paternal Grandparent |
| <input type="checkbox"/> Blindness | Parent / Sibling / Maternal Grandparent / Paternal Grandparent |
| <input type="checkbox"/> Diabetes | Parent / Sibling / Maternal Grandparent / Paternal Grandparent |
| <input type="checkbox"/> Cancer | Parent / Sibling / Maternal Grandparent / Paternal Grandparent |
| <input type="checkbox"/> Heart Disease | Parent / Sibling / Maternal Grandparent / Paternal Grandparent |
| <input type="checkbox"/> 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

Respiratory

- Cough
- Congestion
- Wheezing
- Asthma

Blood / Lymphnodes

- Easy Bruising
- Gums Bleed Easy
- Prolonged Bleeding
- Heavy Aspirin Use

Gastrointestinal

- Heartburn
- Nausea / Vomiting
- Jaundice / Hepatitis

MusculoSkeletal

- Stiffness
- Arthritis
- Joint Pain / Swelling

Ear, Nose, and Throat

- Hard of Hearing
- Ringing in Ears
- Vertigo

Genito-Urinary

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

Skin

- Rash / Sores
- Lesions
- Hives / Eczema

Cardiovascular

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

Psychiatric

- Anxiety / Depression
- Mood Swings
- Difficulty Sleeping

Neurological

- Seizures
- Weakness / Paralysis
- Numbness
- Tremors

Constitutional

- Fatigue / Weakness
- Fever
- Weight Gain / Loss

Endocrine

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

Immunologic

- Hives
- Itching
- Runny Nose
- Sinus Pressure