Eduardo Besser, MD
MEDICAL + SURGICAL EYE CARE

NEW PATIENT REGISTRATION

PERSONAL

Name (*last, first*) _____ **M.I.** _____

Gender: ◯ **Male** ◯ **Female** ◯ **Nonbinary** **Preferred pronouns** _____

Street address _____

City _____ **State** _____ **Zip** _____

Email _____

Home phone ( ) - **Work** ( ) - **Cell** ( ) -

Social Security # - - **Date of Birth** **Age** _____

Birth State _____ **Mother's Maiden Name** _____ **Marital Status** _____

Preferred Language with Clinician _____

Are you of Hispanic or Latino origin or descent? ◯ **yes, Hispanic or Latino** ◯ **no, not Hispanic or Latino**

What is your race? *Please mark one or more*

- ☐ **White**
- ☐ **Black or African-American**
- ☐ **Asian**
- ☐ **Native Hawaiian or other Pacific Islander**
- ☐ **American Indian or Alaska Native**

EMPLOYMENT

Employer _____ **Occupation** _____

INSURANCE

Primary Insurance: _____

Policy # _____ **Group #** _____ **Phone** ( ) -

Name of Subscriber _____ **Date of Birth**

Subscriber's SS # - - **Relationship to Insured** ◯ **Self** ◯ **Spouse** ◯ **Other**

Secondary Insurance _____

Policy # _____ **Group #** _____ **Phone** ( ) -

Name of Subscriber _____ **Date of Birth**

Subscriber's SS # - - **Relationship to Insured** ◯ **Self** ◯ **Spouse** ◯ **Other**

NEW PATIENT REGISTRATION / PAGE 2

Referred by _____

City _____ **State** _____ **Zip** _____

Phone ( ) - **Fax** ( ) -

Emergency Contact _____ **Relation** _____

Phone ( ) -

How did you hear about our practice? _____

PAYMENT

By providing your credit card information below, you authorize payment for uncovered services and/or those that are determined to be your responsibility by your health plan. If you choose not to provide your credit card authorization, be aware that your account will be subject to penalty fees per month for any outstanding balance. Our practice has implemented stringent security measures to protect your credit card information and will make every attempt to contact you when charging your account.

Credit Card # (*MC / VISA / AMEX*) _____ **Exp. Date**

Signature _____ **Date**

Name (*print*) _____

I certify that all information provided is true and accurate. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account. I authorize payment of medical benefits to Angeles Eye Institute when assignment has been taken. I have read the office financial policy and agree to all terms and conditions. I authorize Angeles Eye Institute to use or disclose any information for treatment, payment, and healthcare operations. I authorize that the physicians and/or employees of Angeles Eye Institute can contact me via all necessary means (phone, email, fax, etc) or leave me a message if they are unable to contact me directly. I acknowledge that I have received a copy of the Notice of Privacy Practices.

_____ _____

PATIENT SIGNATURE DATE

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PATIENT HISTORY FORM: FIRST VISIT / PAGE 1

Patient _____ **M/R #** _____

Please answer the following questions about your health. *Continue on reverse if you need more room.*

Have you ever been treated for any medical conditions?

Diabetes	○ NO	○ YES
High Blood Pressure	○ NO	○ YES
Heart Disease	○ NO	○ YES

Others (*please explain*): _____

Have you ever had any eye disease?

Glaucoma	○ NO	○ YES
Cataracts	○ NO	○ YES
Macular Degeneration	○ NO	○ YES
Diabetic eye disease	○ NO	○ YES

List any others below: _____

Have you had eye surgery (including laser surgery)? If so, give details below.

TYPE OF SURGERY	DATE	WHICH EYE?	
		○ LEFT	○ RIGHT
		○ LEFT	○ RIGHT
		○ LEFT	○ RIGHT
		○ LEFT	○ RIGHT

Have you ever had surgery or been hospitalized? *Please describe:* _____

Do you take any medications (including eye drops)? ○ NO ○ YES *Please list:* _____

Do you have any drug or food allergies?: ○ NO ○ YES *Please list:* _____

Do any **medical or ocular** diseases run in your family? _____

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Patient _____

M/R # _____

Do you currently have any of the following problems?

Chronic fever, unexplained weight loss, fatigue?	NO	YES
Ear/Nose/Throat problems (*sinusitis, etc.*)	NO	YES
Respiratory problems (*shortness of breath, coughing, etc.*)	NO	YES
Heart problems (*chest pain, palpitations, etc.*)	NO	YES
Gastrointestinal problems (*diarrhea, nausea, abdominal pain*)	NO	YES
Urinary problems (*pain or blood in urine, etc.*)	NO	YES
Skin problems (*rashes, etc.*)	NO	YES
Musculoskeletal problems (*joint pain, swelling*)	NO	YES
Neurologic problems (*weakness, numbness, headache, etc.*)	NO	YES
Psychiatric problems (*depression, insomnia, etc.*)	NO	YES

Allergy Symptoms

Asthma	NO	YES	Dark circles under eye	NO	YES
Runny nose	NO	YES	Itchy/flaky skin	NO	YES
Congestion	NO	YES			

Eyes

Blurred Vision	NO	YES	Dry, sandy, gritty	NO	YES
Double Vision	NO	YES	Foreign body sensation	NO	YES
Floaters	NO	YES			

Other _____

Do you smoke?	NO	YES	How much?	_____
Drink alcohol?	NO	YES	How much?	_____

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GENERAL EYE QUESTIONNAIRE

Does your sight make it difficult to:	Always	Sometimes	Never
Drive during the day?	○	○	○
Drive at night	○	○	○
Read small print, medicine bottles, phone book, etc.	○	○	○
Read a newspaper or book	○	○	○
Read large-print books, large-print newspapers, or numbers on a phone	○	○	○
Recognize people when they are close to you	○	○	○
See steps, stairs or curbs	○	○	○
Read traffic signs, street signs, or store signs	○	○	○
Do fine handiwork like sewing, knitting, or carpentry	○	○	○
Fill out forms	○	○	○
Play games such as bingo, dominoes, cards	○	○	○
Take part in sports such as tennis or golf	○	○	○
Cook	○	○	○
Watch television	○	○	○

PATIENT SIGNATURE

DATE

ASSIGNMENT OF BENEFITS

I hereby assign all medical and and/or surgical benefits, to include major medical benefits to which I am entitled including Medicare, private insurance, and any other health plans to Angeles Eye Institute. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize the said assignee to release all information necessary to secure payment.

SIGNED _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize Angeles Eye Institute to furnish all necessary information it may have regarding my condition under Dr. Besser's observation or treatment, physical findings, diagnosis and prognosis, to my insurance company(ies) and/or physicians.

SIGNED _____

PAST DUE BALANCES

Should my account be unpaid after 90 days (unless other financial arrangements have been made), I understand that my account will be turned over to a collection agency. Should any additional costs be incurred due to this action. I understand that I will be responsible for them in addition to my unpaid balance.

SIGNED _____

DATE _____

OUR FINANCIAL POLICY

We are dedicated to providing the best possible care for you, and we want to ensure that you completely understand our financial policies.

1. Payment is due at the time of service unless arrangements have been made in advance by your carrier. We accept Visa and MasterCard.

2. Keep in mind that your insurance policy is basically a contract between you and your insurance company. As a service to you, we will file your insurance claim if you assign the benefits to the doctor–in other words, if you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. If we later receive a check from the insurer, we will refund any overpayment to you.

3. We have made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits. We will bill them, and you are required to pay a co-payment at the time of your visit.

4. If you are insured by a plan that we do not have prior arrangements with, we will prepare and send the claim for you on an unassigned basis. This means the insurer will send the payment directly to you. Therefore, our charges for your care are due at the time of service.

5. Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

6. We will bill your insurance company for all services provided in the hospital. You are responsible for any balance due.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

SIGNATURE OF PATIENT (OR RESPONSIBLE PARTY, IF MINOR) DATE

PRINT PATIENT NAME

SIGNATURE OF WITNESS DATE

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INFORMATION REGARDING DILATING EYE DROPS

Dilating drops are used to dilate or enlarge the pupils of the eye, allowing the ophthalmologist to get a better view of the inside of your eye.

Dilating drops frequently blur vision for a length of time, which varies from person to person, and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it's best if you make arrangements not to drive yourself.

Adverse reactions, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize Dr. Eduardo Besser, and/or such assistants as may be designated by him, to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

PATIENT (OR PERSON AUTHORIZED TO SIGN FOR PATIENT) _____ DATE _____

WITNESS _____ DATE _____