EYE ASSOCIATES OF NORTH ATLANTA, LLC

Patient Registration Form

PLEASE COMPLETE ALL OF THE INFORMATION BELOW

Last Name: __________________ First Name: ____________ Middle Initial: _____ Date of Birth: ___________
Address: ______________________________________ City: ______________ State: _____ Zip Code: ______
Home/Mobile Phone: ___________________________ Email: _____________________________ Gender: ___
Marital Status (circle one): Single Married Divorced Separated Social Security #: ________________
Spouse/Partner Name (if applicable): _________________ Profession/Employer: _________________________
Race: ____________ Ethnicity (circle one): Hispanic or Latino Non-Hispanic or Latino Unknown Declined
Referring Provider/Optometrist: ______________________________________ Phone: ____________________
Address: ____
Preferred Pharmacy: ____ Phone: ____________________
Address: ____
Primary Care Physician: ____ Phone: ____________________
Address: ____
Emergency Contact (include relationship): _____________________________ Phone: ____________________
How did you hear about us? ____________________ If online, which website(s)? ________________________

PRIMARY INSURANCE:
Person responsible for account: _______________________________ Phone: ___________________________
Relationship to Patient: _____________________________________ Date of Birth: ______________________
Address (if different from patient): ____
Ins. Company and Address: ____
Subscriber ID#: _______________________ Group Name/#: ___________________Co-pay: $_____________

ADDITIONAL/SECONDARY INSURANCE (if applicable):
Person responsible for account: _______________________________ Phone: ___________________________
Relationship to Patient: _____________________________________ Date of Birth: ______________________
Address (if different from patient): ____
Ins. Company and Address: ____
Subscriber ID#: _______________________ Group Name/#: ___________________Co-pay: $_____________

Consent for Treatment

I authorize Anand K. Shah, M.D. and Eye Associates of North Atlanta, LLC to provide me with medical care and to dilate, test, and examine my eyes as necessary to determine the underlying cause of my visual difficulties (if any) and to offer treatment options available to me as warranted. I understand some of the services advised by my doctor may or may not be covered by insurance and that I am financially responsible for all services rendered. I also agree to promptly pay in full any outstanding balance within 30 days of receiving a bill.

Signature of Patient or Responsible Party __________________________Date ______________________

Patient Name: ______________________
DOB: ______________________

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History and Intake Form

L = Left R = Right B = Both

Past Medical History: (Please check all that apply)

Anemia		COPD		Hyperthyroidism	
Anxiety		Coronary Artery Disease		Hypothyroidism	
Arthritis		Depression		Leukemia	
Artificial Joints		Diabetes		Lung Cancer	
Asthma		End Stage Renal Disease		Lymphoma	
Atrial Fibrillation		GERD		Prostate Cancer	
BPH		Hearing Loss		Pacemaker	
Bone Marrow Transplantation		Hepatitis		Seizures	
Breast Cancer		Hypertension		Stroke	
Colon Cancer		HIV/AIDS		Valve Replacement	
Congestive Heart Failure		Hypercholesterolemia		None	

Other: ____

Past Surgical History: (Please note all that apply)

	Date		**Date**		**Date**
Appendectomy		Gallbladder Removed		Oophorectomy (L,R,B)	
Bladder Removed		Coronary Bypass		Prostatectomy	
Mastectomy (L,R,B)		Heart Transplant		Skin Biopsy	
Lumpectomy (L,R,B)		Kidney Biopsy (L,R,B)		Skin Cancer Removal	
Breast Biopsy (L,R,B)		Kidney Removal (L,R,B)		Melanoma Removal	
Colectomy/Resection		Hysterectomy		Spleen Removal	

Other (Please include date(s)): ____

Ocular History: (Please check all that apply)

Allergic Conjunctivitis		Glaucoma (L,R,B)		Pseudoexfoliation (form of Glaucoma)	
Eyelid Inflammation		Macular Degeneration (L,R,B)		Retinal Tear (L,R,B)	
Cataract (L,R,B)		Macular ERM (L,R,B)		Strabismus (lazy eye)	
Corneal Dystrophy (L,R,B)		Narrow Angles (L,R,B)		Dry Eyes (L,R,B)	
Diabetic Retinopathy (L,R,B)		Ocular Hypertension (L,R,B)		Vitreous Floaters (L,R,B)	
Glasses/Contacts		Ophthalmic Migraine		None	

Other: ____

Patient Name: ______________________
DOB: ______________________

Ocular Surgery: (Please check all that apply)

Blepharoplasty (L,R,B)		LASIK (L,R,B)		Strabismus surgery	
Cataract Surgery (L,R,B)		LPI (L,R,B)		Retinal laser (L,R,B)	
Corneal Transplant (L,R,B)		LTP (L,R,B)		Trabeculectomy (L,R,B)	
DSAEK (L,R,B)		PRK (L,R,B)		Tube Shunt (L,R,B)	
Eye Muscle Surgery		Ptosis repair (L,R,B)		Yag Capsulotomy (L,R,B)	
Intravitreal injection (L,R,B)		Punctal plugs (L,R,B)		None	

Other: ____

Medications: (Please list all current medications)

Medication	Dosage	Frequency

Allergies: (Please list all allergies and associated reactions)

Social History: (Please circle all that apply)

Do you drive?	YES	NO		
Do you drive at night?	YES	NO		
Do you have pets?	YES	NO		
Do you drink alcohol?	YES	NO	If so, how many drinks/week?	__________
Do you use tobacco/smoke?	YES	NO	If so, how many packs/day?	__________

Family History: (If applicable, please list all family member(s) affected)

Blindness		Diabetes		Migraine	
Cancer		Glaucoma		Retinal detachment	
Cataracts		Heart disease		Strabismus/Lazy Eye	
CVA/Stroke		Macular degeneration		Other	

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Review of Systems: (For the following symptoms, please check the symptoms you currently have)

Poor Vision		Congestion		Rash	
Eye Pain		Wheezing		Skin Lesions	
Tearing		Shortness of Breath		Headache	
Redness		High Blood Pressure		Numbness	
Jaw Pain		Rapid Heart Beat		Tingling	
Scalp Tenderness		Chest Pressure/Pain		Focal Weakness	
Loss of Vision		Nausea		Vertigo/Imbalance	
Floaters		Vomiting		Anxiety	
Fever		Diarrhea		Depression	
Chills		Constipation		Insomnia	
Weight Loss		Abdominal Pain		Diabetes	
Fatigue		Burning on Urination		Heat Intolerance	
Stuffy Nose		Urinary Frequency		Cold Intolerance	
Ear Ache		Incontinence		Bleeding Disorders	
Hearing Loss		Joint pains		Anemia	
Dry Mouth		Stiffness		Allergies	
Sore Throat		Arthritis		Itching	
Cough		Dry Skin		Hives	

Other: ____

Alerts:

Blood Thinners		Defibrillator		Problems w/ anesthesia	
Allergy to adhesive		Flomax		Rapid heartbeat with epinephrine	
Allergy to lidocaine		MRSA		Pregnancy/planning pregnancy	
Artificial heart valve		Narrow angles		Pseudoexfoliation	
Artificial joints		Pacemaker		Steroid responder	

Other: ____

Patient Name: ____________________
DOB: ____________________

Authorization for the Use or Disclosure of Protected Health Information

Our Notice of Privacy Practices ("Notice") provides information about how we may use and disclose protected health information about you. As provisioned by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), you have certain rights to privacy regarding your protected health information, and this form is provided to comply with this Act. You have the right to review and obtain a copy of our Notice before signing this consent. The terms of the Notice may be changed and/or updated at any time at the discretion of Eye Associates of North Atlanta, LLC. If we change/amend our Notice, you may obtain a revised copy by contacting our office at 5755 North Point Parkway, Suite 94, Alpharetta, GA, 30022.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations, and acknowledge understanding of our Privacy Practices. *You also acknowledge that you have received and/or have declined a copy of our Notice of Privacy Practices*. You have the right to revoke this Consent, in writing and with signature, at any time. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent.

Signature of Patient or Responsible Party __________________________Date_________________

I authorize Eye Associates of North Atlanta, LLC, and Anand K. Shah, M.D. to request, use, and transmit my prior medical records and prescription medication history to/from my primary care physician and/or other healthcare providers for diagnostic and treatment purposes.

Signature of Patient or Responsible Party __________________________Date_________________

I authorize Eye Associates of North Atlanta, LLC, and Anand K. Shah, M.D. to release my medical information, records, and prescription medication history to my emergency medical contact.

Name of Emergency Contact (relationship) _________________________Phone _______________

Signature of Patient or Responsible Party __________________________Date_________________

Patient Name: ______________________
DOB: ______________________

EYE ASSOCIATES OF NORTH ATLANTA, LLC

Financial Policy

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your responsibility.

- **Eye Associates of North Atlanta, LLC** will accept assignment on your insurance benefits and will expedite insurance claim processing to ensure prompt payment and accurate reimbursement.
- **Patient Responsibility**
  - The Patient is responsible for all fees. Full payment is due at the time of service unless other arrangements have been made in advance. Returned checks will be assessed a $25 fee.
  - Deductibles and co-payments are due at the time of service on all insurance plans.
  - Patients covered under non-participating insurances must pay 100% of any unpaid deductible or out of pocket expenses under the terms of their contract.
  - If insurance payment is not received within 60 days of your date of service, the Patient becomes responsible for any outstanding balance not received within 60 days of service.
- **Finance Charges**
  - A Finance charge of 2% will be assessed against the outstanding balance for any amount owed over 60 days. This charge will be assessed monthly until the account is paid in full.
  - Delinquent unpaid balances will be forwarded to a collection agency or attorney.
- **Late/No Show Fee: $75**
  - A Late/No Show Fee will be assessed if the Patient does not cancel/reschedule within 24 hours of the appointment or arrives 30 or more minutes past the scheduled appointment time.
  - Late Patients may be worked into the schedule if time allows, but this is not a guarantee.

I have read and understand this financial policy, agree to its terms, and will comply with payment policies for services rendered. I agree to pay attorney fees and collection costs in the event it becomes necessary to retain such services for collection of my account.

Furthermore, I authorize the release of medical information and records concerning my treatment to Medicare, Medigap, and/or other commercial insurance companies and assign my insurance benefits for services provided to be paid directly to Eye Associates of North Atlanta, LLC to the extent permitted under applicable law or insurance agreements. I release all legal responsibility or liability that may arise from the above authorizations and agreements:

Signature of Patient or Responsible Party ________________________ Date ______________________

Patient Name: ______________________

DOB: ______________________

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Preparing For Your Upcoming Visit

We are looking forward to your upcoming visit. To help you prepare, please be aware of the following:

1. Please be prepared to spend 1-2 hours with us for your initial visit.

Your initial visit with Dr. Shah will include a detailed history, comprehensive eye and retinal examination, and additional testing as needed. Dr. Shah will develop and review a customized diagnosis and treatment plan with you based on the results, answer any questions you may have, and begin initial treatment if needed.

2. Your eyes will be dilated (eye drops will be placed to enlarge your pupil) during your examination.

While the dilation wears off 4-6 hours after placement, your vision may be blurred and your eyes may be light sensitive during this time. It is best to have someone to drive you after your initial appointment. For subsequent appointments, you can decide whether you need a driver.

3. It is often helpful to have a family member or friend accompany you to your initial appointment.

Depending on your eye condition and findings, Dr. Shah may recommend various treatment options and provide accompanying information to assist with decision making. Having a family member or friend participate can help you to recall information discussed during your visit.

4. Please bring the following to your appointment:

- ☐ Completed New Patient forms
- ☐ Your current eyeglasses or contacts
- ☐ A list of your medications, including eye drops and vitamins
- ☐ List and dates of past medical issues and surgical procedures
- ☐ List of doctors you are seeing and the referring doctor's name
- ☐ A copy of your insurance card and a photo ID, such as a driver's license

If you have any questions, please call our office at (470) 767-8287

Patient Name: ______________________
DOB: ______________________