MEDICAL HISTORY

NAME: _____ **DATE**

Reason for Today's Exam: _____ Last Eye Exam : _____

EYE SURGERY/LASER YES / NO _____

SOCIAL HISTORY

Does your vision limit any activities of daily living (driving, reading, sports, work, personal hygiene, cooking, cleaning, etc.?) YES / NO

Do you wear glasses / contact lenses? YES / NO

Do you drive? YES / NO

Occupation _____

Marital status: Single / Married / Divorced / Widowed

FAMILY HISTORY (Mother, Father, Grandparent, Sibling)

Has any member of your family had these diseases (circle all that apply)? YES NO UNKNOWN

Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis

Other:

SYSTEMATIC MEDICAL HISTORY: Do you currently have problems in the following areas?

	YES	NO	Details
GENERAL/CONSITITUTIONAL (fever, heat stroke, weight, loss/gain, unusually tired, etc.)			
EARS, NOSE, THROAT (hard of hearing, stuffy nose, running nose, sinus congestion, earache, cough, dry mouth, etc.)			
CARDIOVASCULAR (high blood pressure, chest pain, racing pulse, arrhythmia, etc.)			
RESPIRATORY (congestion, wheezing, shortness of breath, asthma, emphysema, bronchitis, etc.)			
GASTROINTESTINAL (stomach upset, gastritis, diarrhea, constipation, hernia, ulcers, etc.)			
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, incontinence, impotence, etc.)			
FEMALES (are you pregnant? Nursing? Breast problem, etc.)			
MUSCLES, BONES, JOINTS (joint pain, back pain, muscle pain, stiffness, swelling, cramps, arthritis, etc.)			
SKIN (pimples, warts, growths, rash, skin cancer, acne, rosacea, etc.)			
NEUROLOGICAL (numbness, headache, migrane, seizures, stroke, paralysis, tremor, multiple sclerosis, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia, dementia, etc.)			
ENDOCRINE (diabetes, hypo/hyperthyroid, myasthenia gravis, etc.)			
BLOOD/LYMPH (bleeding, cholesterolemia, anemia, blood transfusion, etc.)			
ALLERGIC/IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, hay fever, etc.)			

MEDICATIONS _____

ASPIRIN/ COUMADIN/ PLAVIX YES / NO _____

ALLERGY TO MEDICATIONS YES / NO _____

Signature _____

BRONX EYE ASSOCIATES
REGISTRATION FORM

(Please Print)

Today's Date _____/_____/_____ PCP_____

PATIENT INFORMATION

Patient's Last Name	First	Middle	❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Wid

Full time student? ❑ Yes ❑ No	E-mail address (if applicable)	Social Security	Birth Date / /	Age	Sex ❑ M ❑ F

Street Address	Apt #	City	State	ZIP Code	Home Phone No. ( )

Occupation	Employer	Employer Phone No. ( )

Referred to Bronx Eye Associates by ❑ Dr. ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Yellow Pages ❑ Other

Name and Telephone of Primary Care Physician

INSURANCE INFORMATION

PLEASE GIVE INSURANCE CARD TO THE RECEPTIONIST

Is this patient covered by insurance? ❑ Yes ❑ No

Subscriber's Name	Subscriber's S.S. #	Birth Date / /	ID #	Sex ❑ M ❑ F	Co-Payment $

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of Secondary Insurance (if applicable)	Subscriber's Name	Group #	Policy #

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Patient	Phone No. ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize **Bronx Eye Associates** or insurance company to release any information required to process my claims.

X _____

PATIENT/GUARDIAN SIGNATURE DATE

Bronx Eye Associates

665 Pelham Pkwy North Suite 202

Bronx, NY 10467

Tel. (718)547-2020

Fax. (718)547-3021

CONSENT FOR MINOR SURGERY

I, _____

Dr. Eleonora Orloff

Dr. Simona Korik-Barrett

Dr. Viren Patel

Dr. Sanaz Ooriel

Dr. Yuliya Bababekova

To perform PROKERA/MORIA AMNIO TISSUE INSERTION, a minor surgical in-office procedure under local anesthesia.

The risk and benefits have been explained to my satisfaction.

Patient signature_____

Date: 11/17/2017

Bronx Eye Associates

665 Pelham Parkway North Suite 202
Bronx, NY 10467
Tel. (718) 547-2020
Fax (718) 547-3021

Date **Friday, November 17, 2017**

Patient Name _____

I understand that a portion of my comprehensive eye exam will be billed to my medical insurance (e.g. diagnostic imaging and testing for ocular disease such as glaucoma, cataract, ect.)

With the full understanding of the above, I consent to being responsible for co-payments, coinsurance and/or deductibles.

I also understand that I am responsible for providing accurate and up to date insurance information, including all primary holder(subscriber)information. As a result of incorrect information, I will be billed the balance for services.

_____
Patient Signature

Bronx Eye Associates
665 Pelham Parkway North Suite 202
Bronx, NY 10467
Tel. (718) 547-2020
Fax (718) 547-3021

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: **DOB:**

I have been presented with a copy of **Notice Privacy Practices**, detailing how my information may be used and disclosed as permitted under federal and state law. I understand and agree with the contents of the Notice.

I also hereby consent to the disclosure of my health information for the following purposes: (1) to provide my health care treatment; (2) to obtain payment for the services provided to me; and (3) to carry out ordinary health care and business operations.

_____ _____

Signature Date