Arizona Retina Institute

Patient Registration Form

Patient's Name: ______________________________ Today's Date:______/____/___

Patient's Social Security#______________________ Date of Birth:______/____/___

Gender: Male ___ Female___

Marital Status: Single___ Married___ Widowed___ Divorced___

Home Address:_________________________ Home Phone # :________________

_________________________ Cell Phone # :__________________

Occupation:___________________________ Employer:_____________________

Employer Address:______________________________ Work Phone:______________

____

Emergency Contact:______________________ Relationship:_________________

Phone #_______________________

Primary Eye Doctor

____

Primary Care Physician

____

Referring Doctor: _________________________________

Do you have insurance? ____________

Arizona Retina Institute

Primary Insurance Information

Name of Insurance Company:______________________ Effective Date: ____/____/____

Subscriber ID# ____________________________ Group # _______________________

Policy Holder's Name:______________________ Relation to patient: _______________

Secondary Insurance Information

Name of Insurance Company:____________________ Effective Date: ____/____/____

Subscriber ID# ____________________________ Group #__________________________

Policy Holder's Name: ________________________ Relation to patient: _______________

Authorization to release

I hereby authorize Arizona Retina Institute to furnish the insured's insurance company all information which said insurance company may request concerning my present claim.

Assignment of insurance benefits

I hereby assign to the Arizona Retina Institute (ARI) all reimbursement to which I am entitled for expenses relative to the services performed from time to time, but not to exceed my indebtedness to ARI. It is understood that any reimbursement received from the above named insurance company over and above my indebtedness will be refunded to me when my bill is paid in full. I understand that I am financially responsible to ARI for charges for all the charges for all services rendered.

______________________________ ___________________________ ______

Responsible Party's Signature Patient's Signature Date

Patient Health History Questionnaire

Reason for your visit: ____

OCULAR HISTORY

Please tell us about any previous eye problems, condition or surgeries:

____

MEDICATIONS

List all Medications you are currently taking.

(Include dosage and frequency)

____
____
____
____
____
____
____
____
____
____

EYE MEDICATIONS

List all eye drops you are currently taking.

(Include dosage and frequency)

____
____
____
____
____

Are you or have you ever been on any of the following medications:

Plaquenil (Hydroxychloroquine)
Elmiron (Pentosan Sulfate)
Mellaril (Thioridazine)
Desferal (Deferoxamine)
Niacin
Tamoxifin

ALLERGIES

No known drug allergies

List all allergies to medication/other substances.

YOUR PHARMACY INFORMATION

Pharmacy Name ____

Address ____

REVIEW OF SYSTEMS

Do you currently have any problems in the following areas? *(Please circle "YES" or "NO")*
If "YES" Please explain.

Constitution Symptoms Yes No____
Ex: hearing, fatigue, weight loss or gain, loss of appetite

Ear, nose, mouth & Throat problems: Yes No_______________________________________
Ex: hearing loss, sinus congestion, chronic cough, dry mouth

Cardiovascular problems Yes No ____
Ex: Chest pain, irregular heartbeat, swollen feet

Respiratory problems Yes No ____
Ex: Shortness of breath, wheezing, asthma, bronchitis

Gastrointestinal problems Yes No____
Ex: heartburn, abdominal pain, ulcers, diarrhea or constipation

Musculoskeletal problems Yes No ____
Ex: Muscle, aches or weakness, swollen or stiff joints, arthritis

Endocrine problems Yes No ____
Ex: Thyroid disease, diabetes

Skin Disease Yes No ____
Ex: Rash, eczema, dermatitis, pigmented lesion, breast lump

Neurologic problems Yes No ____
Ex: numbness or tingling, weakness/paralysis, stroke, seizures

Psychiatric problems Yes No ____
Ex: Depression, anxiety, memory loss, confusion

Hematologic/ Lymphatic Yes No____
Ex: Anemia, bleeding or bruising tendency, swollen lymph nodes

SOCIAL HISTORY

Do you or have you use alcohol? Yes No ______________________________

Do you or have you smoked? Yes No _________________________________

PAST MEDICAL HISTORY

Place a mark on "YES" or "NO" to indicate if you have a medical history of any of the following:

Diabetes	Yes	No
Blood Pressure	Yes	No
Heart Disease/ attack	Yes	No
High Cholesterol	Yes	No
Stroke	Yes	No
Cancer	Yes	No
HIV/AIDS	Yes	No

Other ____

FAMILY HISTORY

Circle "YES" or "No" to indicate if there is a history of any of the following in your family.

Diabetes	Yes	No	Who?	____
High Blood Pressure	Yes	No	Who?	____
Heart Disease	Yes	No	Who?	____
Cancer	Yes	No	Who?	____
Retinal Detachment	Yes	No	Who?	____
Macular Degeneration	Yes	No	Who?	____
Other ________________________________			Who?	____

Arizona Retina Institute

Notice of Privacy Practices

To our patients. This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy
Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information.

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuit and similar proceedings in response to a court or administrative order.
3. If required to do so by law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or another individual or the public. We will only make disclosure to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligences and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For workers Compensation and similar programs.

Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home rather than work. We will accommodate reasonable request.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for you care, such as family members and friends. We are not required to agree to your request; however if we agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to *(Arizona Retina Institute, Sharam Danesh MD, Privacy Officer, 3811 E. Bell Rd Suite 106, Phoenix, AZ 85032)*
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to *(Arizona Retina Institute, Sharam Danesh MD, Privacy Officer, 3811 E. Bell Rd Suite 106, Phoenix, AZ 85032)* You must provide us with a reason that supports your request for amendment.
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the security of the Department of Health and Human Services. To file a complaint with our practice, contact *(Sharam Danesh MD, Privacy Officer, 3811 E. Bell Rd Suite 106, Phoenix, AZ 85032)*
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact *(Arizona Retina Instittue @ 602-368-3448)*

I hereby acknowledge that I have been presented with a copy of Arizona Retina Institute.
Notice of Privacy Practices.

Patient Name (Print)

____

Signature

____

Date

____

Medicare Authorization of Payment

_______________________________________ _______________________________

Beneficiary Name (PRINT) Medicare ID Number

Medicare:

I request that payment of authorized Medicare benefits be made on my behalf to Arizona Retina Institute, for services furnished me by Dr. S. Danesh. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes releases of medical information necessary to pay the claim.

Arizona Retina Institute accepts the charge determination of the Medicare carrier, as the full charge, and the patient is responsible for the deductible, coinsurance, copay and noncovered services. Coinsurance, Copay and Deductible are based upon the charge determination of the Medicare carrier.

Coinsurance/Private Insurance:

If a second policy or other health insurance is indicated, I hereby authorize payment of my medical and surgical insurance benefits to Arizona Retina Institute. I understand I am financially responsible for any charges whether or not paid by said insurance. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Arizona Retina Institute. I authorize Arizona Retina Institute to release any information required to process any and all claims for reimbursement on my behalf. A copy of this authorization may be used in place of my original signature.

_______________________________ _______________________________

Signature Date

_______________________________ _______________________________

Signature Date