

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 # : \_\_\_\_\_

Email Address: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_

\_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone # \_\_\_\_\_

Primary Eye Doctor

Primary Care Physician

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Phone # \_\_\_\_\_

Phone # \_\_\_\_\_

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

**Your Pharmacy Information**

Pharmacy Name \_\_\_\_\_  
Address \_\_\_\_\_  
Phone Number \_\_\_\_\_

# Patient Health History Questionnaire

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Family Physician's Name \_\_\_\_\_ Phone: \_\_\_\_\_

**Reason for your visit:** \_\_\_\_\_

## Ocular History

Please circle "YES" or "NO" to indicate if you have had any of the following:

Macular Degeneration	Yes	No	Retinal Detachment	Yes	No	Diabetetes in Eyes	Yes	No
Loss of Vision	Yes	No	Distorted Vision	Yes	No	Blurred Vision	Yes	No
Floater/flashs	Yes	No	Loss of side vision	Yes	No	Poor color vision	Yes	No
Poor Night Vision	Yes	No	Severe Nearsidedness	Yes	No	Eye trauma	Yes	No
Eye Pain	Yes	No	Eye redness	Yes	No	Corneal Disease	Yes	No

Other \_\_\_\_\_

## Past Medical History

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

High Blood Pressure	Yes	No	Diabetes	Yes	No	Arthritis	Yes	No
Heart Disease/ attack	Yes	No	Stroke	Yes	No	Cancer	Yes	No
Lung Disease/ Asthma	Yes	No	Thyroid Disease	Yes	No	HIV/AIDS	Yes	No

Other \_\_\_\_\_

## Past Surgical History

List all past medical surgeries (not including eye surgery-see below).

_____	Date _____	_____	Date _____
_____	Date _____	_____	Date _____
_____	Date _____	_____	Date _____

Have you ever had any adverse reaction to local general anesthesia? Yes No

If yes, please explain type of reaction. \_\_\_\_\_

## Allergies

No known drug allergies

List all allergies to medication/other substances.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Eye Surgeries

List all eye surgeries

\_\_\_\_\_ Date \_\_\_\_\_  
\_\_\_\_\_ Date \_\_\_\_\_  
\_\_\_\_\_ Date \_\_\_\_\_

## 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?	_____
Stroke	Yes	No	Who?	_____
Cancer	Yes	No	Who?	_____
Macular Degeneration	Yes	No	Who?	_____
Severe Nearsightedness	Yes	No	Who?	_____
Retinal Detachment	Yes	No	Who?	_____
Retinitis Pigmentosa	Yes	No	Who?	_____
Glaucoma	Yes	No	Who?	_____
Cataract	Yes	No	Who?	_____
Other _____			Who?	_____

## Social History

Occupation \_\_\_\_\_ Retired \_\_\_\_\_  
(Circle one) Single Married Divorced Widowed  
Do you live with- Alone With spouse other \_\_\_\_\_  
Do you or have you used recreational drugs? Yes No \_\_\_\_\_  
Do you or have you use alcohol? Yes No How much? \_\_\_\_\_ How long? \_\_\_\_\_  
Do you or have you smoked? Yes No How much? \_\_\_\_\_ How long? \_\_\_\_\_

## Medications

List all Medications you are currently taking.  
(Include dosage and frequency)

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## Eye Medications

List all eye drops you are currently taking.  
(Include dosage and frequency)

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## 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

**Genitourinary Problems**      Yes    No    \_\_\_\_\_  
Ex: Pain or discomfort, bladder infections, kidney stones

**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

**Allergic/ Immunologic**    Yes    No    \_\_\_\_\_  
Ex: Seasonal allergies, hay fever, HIV

**Cancer**                      Yes    No    \_\_\_\_\_

# 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 Institute @ 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