BAY RIDGE EYE & RETINA SPECIALIST, PC

PATIENT INFORMATION

PATIENT NAME (LAST, FIRST MI Please Print) _____ **DOB** (MM/DD/YYYY) ___/___/___ **AGE** ____

sex ☐ MALE ☐ FEMALE ☐ *__UNDER 18__ (CHECK)

SOCIAL SECURITY (XXX-XX-XXX) ____-____-____

REPRESENTATIVE (Patient under 18 years old, If Applicable) _____ ***Name OF Guardian/Personal Relationship to patient**

STREET ADDRESS (Include Apartment #) _____ **CITY** _____ **STATE** _____ **ZIP** _____

(____) _____ **HOME PHONE NUMBER**

(____) _____ **CELL PHONE NUMBER**

(____) _____ **DAY/WORK/OTHER PHONE NUMBER**

E-Mail Address: _____

☐ MYSELF ☐ GUARDIAN/PERSONAL REPRESENTATIVE ☐ OTHER

FINANCIALLY RESPONSIBLE PERSON (Check One Box)

NAME OF INSURANCE (Primary) _____ **ID/Policy #** (Located on Card) _____ **Group #** (Located on Card) _____

NAME OF INSURANCE (Secondary) _____ **ID/Policy #** (Located on Card) _____ **Group #** (Located on Card) _____

EMERGENCY CONTACT PERSON _____ (____) _____ **PHONE #**

REFERRED BY _____ **FAMILY PHYSICIAN** _____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some Companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-payment, or any other balance not paid for by your insurance company.

IN ORDER TO CONTROL OUR COST OF BILLINGS, WE REQUEST THAT ALL CO-PAYMENTS BE PAID BEFORE THE START OF EACH VISIT.

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and other health plans to Samer A. Khosrof, M.D.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment. If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection. 1.5% per month (18%) may be charged on all balances over 60 days past due.

X _____ _____

PATIENT/GUARDIAN/PERSONAL REPRESENTATIVE SIGNATURE **DATE** (MM/DD/YYYY)

BAY RIDGE EYE & RETINA SPECIALIST, PC

MEDICAL HISTORY QUESTIONNAIRE

PATIENT NAME (LAST, FIRST MI Please Print) _____ **DOB** (MM/DD/YYYY) ___/___/___ **DATE** (MM/DD/YYYY) ___/___/___

NAME OF GUARDIAN/PERSONAL REPRESENTATIVE (Patient under 18 years old, If Applicable) _____

RELATIONSHIP TO PATIENT (If Applicable) _____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

DO YOU CURRENTLY TAKE ANY MEDICATIONS? **YES** **NO**

IF YES LIST MEDICATIONS: _____

DO YOU HAVE ANY ALLERGIES TO ANY MEDICATION? **YES** **NO**

IF YES LIST MEDICATIONS: _____

Have you ever had any of the following problems? YES or NO

MEDICAL PROBLEM	Y	N	MEDICAL PROBLEM	Y	N
CATARACT			HEADACHES		
GLAUCOMA			STROKE		
RETINA PROBLEMS			THYROID PROBLEM		
LAZY EYE			ASTHMA		
BLINDNESS			GASTROINTESTINAL PROBLEMS		
DIABETES			KIDNEY PROBLEMS		
HIGH BLOOD PRESSURE			ARTHRITIS		
HEART PROBLEMS/HEART ATTACK			TUBERCULOSIS/HIV/SYPHILIS		
PROSTHETIC HEART VALVE			CANCER		

HAS ANYONE IN YOUR FAMILY HAD ANY OF THE FOLLOWING PROBLEMS? YES or NO

MEDICAL PROBLEM	Y	N	MEDICAL PROBLEM	Y	N
CATARACT			DIABETES		
GLAUCOMA			HIGH BLOOD PRESSURE		
BLINDNESS			HEART ATTACK/STROKE		

X _____ _____

SIGNATURE OF PATIENT/GUARDIAN/PERSONAL REPRESENTATIVE **DATE** (MM/DD/YYYY)

HIPPA PRIVACY FORM
NOP ACKNOWLEDGEMENT

This form will be provided to you upon registration. In the case of a medical emergency, this form will be provided to you as soon as reasonable practicable after your emergency treatment is over.

PATIENT NAME (Please Print)

NAME OF GUARDIAN/PERSONAL REPRESENTATIVE (Patient under 18 years old, If Applicable)

I. Notice of Privacy

You are entitled to our NOTICE OF PRIVACY PRACTICES describing how your health information can be used and disclosed by BAY RIDGE EYE & RETINA SPECIALIST, PC, and how you can obtain access to and control this information. Our Notice of Privacy Practices will be provided to you upon registration or admission. It is also posted in our registration areas and is available on our website at www.EyeAndRetina.com.

By signing below, I acknowledge that I received the Notice of Privacy Practices provided to me by BAY RIDGE EYE & RETINA SPECIALIST, PC.

X _____ ___/___/___

SIGNATURE OF PATIENT/GUARDIAN/PERSONAL REPRESENTATIVE **DATE**

RELATIONSHIP TO PATIENT (If Applicable)

II. Our practice is dedicated to maintaining the privacy of your individually identifiable health information (also called *protected* health information, or PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

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

- **How we may use and disclose your PHI,**
- **Your privacy rights in your PHI,**
- **Our obligations concerning the use and disclosure of your PHI.**

III. The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

BAY RIDGE
EYE & RETINA
SPECIALIST, PC

INFORMATION REGARDING DILATING EYE DROPS

Dilating drops are used to dilate or enlarge the pupils of the eye to allow 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 reaction, 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 **Samer A. Khosrof, M.D.** and/or such assistants as may be designated by him/her to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

X _____ _____

Patient (or person authorized to sign for patient) Date

_____ _____

Witness Date