White Plains Eye Surgery, P.C.

☐ Kristin Pisacano, MD

☐ Tara Sweeney, MD

REGISTRATION FORM

Patient _____
Last Name First Name

Address: _____

City _____State _____ Zip Code _____

Home Phone: (_____) - _____- _____ Cell Phone: (_____) - _____ - _____

Emergency Contact number _____ Contact Name _____

Social Security Number: _____- _____- _____ Date of Birth: ____- ____- _____ Gender: _____

E-mail Address: _____Referred by: _____

Occupation: _____Work Number: (_____)-_____- _____

Pharmacy Name: _____ Phone: (_____) - _____ - _____

Primary care Physician: _____

Address: _____

Phone Number: _____ Fax: _____

ASSIGNMENT OF PAYMENT

I request that payment of authorized _____ benefits be made
(Name of company)
On my behalf to Dr. Pisacano/ Dr. Sweeny for services furnished to me by this physician. 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 of the benefits payable for related services.

ADDENDUM:
We are happy to participate in your insurance plan and to accept assignment of the charges. This means that we will accept the amount the insurance company approves as our charge and will only bill the difference remaining between what they approve and what they pay.

The exceptions to this rule are for procedures not covered by your insurance companies such as refractions and examinations specifically for Myopia, Presbyopia, Hyperopia, Astigmatism, Headaches and the Fitting of Contact Lenses.

If refraction is performed (check for glasses) the fee of $ 40.00 is not covered by most insurance companies unless you have an eye care rider.
I understand that I am responsible for the payment of the refraction, contact lens fitting or lenses and for any co-pay or deductible my insurance company does not pay.

_____ _____
Signature Date

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CONFIDENTIAL MEDICAL QUESTIONNAIRE

Name: _____ DOB: _____ Date: _____

PAST OCULAR HISTORY:
Previous History of eye treatment or exams: _____

_____

Allergies to medications: _____

Medication: (Please list current Medications) ……

…….....

Do you have any problem with the following areas? Please mark yes or no.

Eyes:

	Yes	No
Decreased vision at distance……	☐	☐
Decreased vision at near……..	☐	☐
Distorted vision……...	☐	☐
Flashing Lights……	☐	☐
Floaters……	☐	☐
Glare/light sensitivity……..	☐	☐
Night blindness……..…	☐	☐
Pain or soreness…….	☐	☐
Styes or chalazion…….	☐	☐
Cataract……	☐	☐
Glaucoma……	☐	☐
Retinal disorder…….	☐	☐
Strabismus (crossed eyes)……	☐	☐
Chronic infection of eye or lid…….	☐	☐

Allergy/ Immunology:

Seasonal allergies……..	☐	☐
Anaphylactic reaction……...	☐	☐

Cardiovascular:

	Yes	No
Hypertension……..	☐	☐
Heart attack……	☐	☐
Irregular heart beat……....	☐	☐
Pacemaker……	☐	☐
Bypass graft……	☐	☐
Chest Pains…….	☐	☐

Endocrine:

High Blood Sugar……...	☐	☐
Low Blood Sugar……	☐	☐
Diabetes……..	☐	☐
Insulin……	☐	☐
Pills…….	☐	☐
Thyroid disorder……	☐	☐

Psychiatric:

Mood Swing……..	☐	☐
Depression…….	☐	☐

Do you smoke? (Y/ N) How much? ……

Do you drink alcohol? (Y/ N) How much? ……

Family History:	**Yes**	**No**	**Unknown**
Macular Degeneration……	☐	☐	☐
Diabetes……..	☐	☐	☐
Glaucoma…….	☐	☐	☐

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment form third-party payers.
- Conduct normal healthcare operation such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient _____ Self / Parent / Other

Signature _____

Date _____

I hereby give my permission for the doctor to discuss my medical information with the following people:

1. _____
2. _____
3. _____
4. _____