Busack Eye Center

PATIENT REGISTRATION FORM Today's Date: _____

Patient Name:_____Prefered Name to be called: _____
(Last) (First) (Middle)

Address: _____ Day time/Cell Phone: _____

City: _____ Home Phone: _____

State: _____ Zip Code: _____ E-Mail Address: _____

Sex: ☐ M ☐ F ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Social Security #: _____/_____/_____ Birth Date: _____/_____/_____ Age: _____

Race: □ American Indian or Alaska Native □ Asian □ Black or African American
□ Native Hawaiian or Other Pacific Islander □ White

Ethnicity: □ Hispanic □ Not Hispanic

Preferred Language: □ English □ French □ Italian □ Japanese
□ Portuguese □ Russian □ Spanish □ Other _____

Pharmacy: _____ Location (Street, City, State) _____

Employer: _____ Business Phone: _____

Business Address: _____ Occupation: _____

Is Condition Work Related? ☐ Yes . ☐ No Person Authorizing Treatment: _____Phone #: _____

If yes, please see the receptionist for Workman's Compensation claim forms.

NEAREST RELATIVE/FRIEND Name: _____

Relationship to Patient: _____Telephone: _____

Nearest Relative/Friend Address: _____

INSURANCE INFORMATION

PRIMARY INSURANCE:

Person Responsible for Insurance: _____
(Last) (First) (Middle)

Relationship to Patient: _____ Birth Date: _____/_____/_____ Soc. Sec. #: ____/____/_____

Address: _____ Home Phone: _____

City: _____ State: _____ Zip Code: _____

Responsible Party Employed By: _____ Business Phone: _____

Business Address: _____ Occupation: _____

Insurance Co: _____ Subscriber ID #: _____ Group #: _____

SECONDARY INSURANCE:

Person Responsible for Insurance: _____
(Last) (First) (Middle)

Relationship to Patient: _____ Birth Date: ____/____/_____ Soc. Sec. #: ____/____/_____

Address: _____ Home Phone: _____

City: _____ State: _____ Zip Code: _____

Responsible Party Employed By: _____ Business Phone: _____

Business Address: _____ Occupation: _____

Insurance Co: _____ Subscriber ID #: _____ Group #: _____

PLEASE COMPLETE IN BLUE OR BLACK INK.

Today's Date _____

PATIENT MEDICAL HISTORY

Name: _____ Referred by: _____ Date of Birth: ____/____/_____

Primary Care Physician: _____Referring /Specialty Dr._____

Optometrist: _____ Where are glasses made? _____

Other Eye Specialist: _____ Previous Ophthalmologist _____

Pharmacy:_____ Location(street & city) _____

Race: □ American Indian or Alaska Native □ Asian □ Black or African American
□ Native Hawaiian or Other Pacific Islander □ White

Ethnicity: □ Hispanic □ Not Hispanic

Preferred Language: □ English □ French □ Italian □ Japanese □ Portuguese
□ Russian □ Spanish □ Other _____

Social History: (Please mark all that apply)

Smoking: □ current every day smoker □ current some day smoker □ former smoker □ never smoked

Alcohol Use: □ Yes □ No If yes how much and how often?_____

Recreational Drug Use: □ Yes □ No If yes what and how often?_____

Do you wear contact lenses? YES NO If yes, last worn? _____

******Contact lenses MUST be removed before seeing technician or physician ******

Medication Allergies and reaction:

_____ _____ _____ _____

_____ _____ _____ _____

Past Eye History: (Please mark all that apply)

□ Overall Healthy
□ Amblyopia (Lazy eye)
□ Aphakia
□ Artery/Vein Occlusion
□ Astigmatism
□ Cataracts
□ Cornea Problem
□ Diabetic Retinopathy
□ Dry Eyes
□ Glaucoma
□ Iritis
□ Keratoconus
□ Macular Degeneration
□ Optic Neuritis
□ Retinal Detachment
□ Contact Lens - Last Worn _____ Other_____

Eye Surgeries: (Please mark all that apply)

□ No prior ocular surgery
□ Blepharoplasty (Eye Lids)
□ Cataract Surgery
□ Corneal Transplant
□ Foreign Body Removal
□ Laser for Glaucoma
□ Laser after Cataract
□ LASIK / PRK
□ Macular Hole
□ Punctal Plugs
□ Retinal Laser Surgery
□ RK
□ Strabismus Surgery (for Crossed Eyes)
□ Trabeculectomy (Glaucoma surgery)
□ Vitrectomy

Surgeon? _____ Date _____ Which eye? Right / Left

Eye Illnesses: (Please mark all that apply)

□ Overall Healthy
□ Diabetes
□ Herpes
□ Lupus
□ Multiple Sclerosis
□ Rheumatoid Arthritis
□ Sjogrens
□ **Plaquenil (Hydroxychloroquine) for auto immune disease-Date begun _____**

Other_____

Current *Eye* Medications: (Please include Name of Medication, eye and frequency)

_____

_____

History of Illnesses:

□ No history of illnesses
□ Anemia
□ Arthritis
□ Arrhythmia
□ Asthma
□ Bleeding Disorder
□ Cancer
□ Congestive Heart Failure
□ COPD
□ Diabetes
□ Eczema
□ Fibromyalgia
□ Headache
□ Hearing Loss
□ Hepatitis
Other _____
□ High Blood Pressure (Hypertension)
□ High Cholesterol
□ HIV
□ Hypothyroidism
□ Kidney Disease
□ Kidney Stones
□ Liver Disease
□ Lung Disease
□ Lupus
□ Migraine
□ Polymyalgia
□ Psychiatric Disorder
□ Skin Cancer
□ Stroke
□ Thyroid Disease

Name: _____ **Date of Birth:** ____/____/_____

General Surgeries / Operations: (Please list or attach list)

_____

_____

_____

Current Other Medications: (Please list or attach list)

_____

_____

_____

□ **Flomax or medication for Prostate issues (please list)** _____

Infections: (Please mark all that apply)

□ Overall Healthy	□ Herpes Simplex	□ HIV / AIDS	□ Syphillis
□ Chicken Pox	□ Herpes Zoster / Shingles	□ Meningitis	□ Toxoplasmosis
□ Hepatitis A / B / C	□ Histoplasmosis	□ MRSA	□ Wound Infection

Other_____

Family History:

□ Diabetes	□ Stroke	□ Blindness	□ Macular Degeneration	□ Arthritis
□ Cancer	□ TB	□ Cataracts	□ Retinal Disease	□ Lazy Eye
□ Heart Disease	□ Kidney Disease	□ Glaucoma	□ High Blood Pressure	□ Retinal Detachment

Other_____

Review of Systems: (Please mark all that apply)

Eyes
- □ Previous Surgery
- □ Contact Lens
- □ Pain
- □ Double Vision
- □ Glaucoma
- □ Cataracts
- □ Macular Degeneration
- □ Dry Eyes
- □ Flashes/Floaters
- □ Blur/Glare/Light Sensitivity
- □ Foreign Body Sensation
- □ Itching/Burning/Watery Eyes
- □ Other_____

Ear, Nose, and Throat
- □ Hard of Hearing
- □ Ringing in Ears
- □ Vertigo

Cardiovascular
- □ Chest Pain
- □ Dizziness
- □ Fainting Spells
- □ Shortness of Breath
- □ Irregular Heart Beat
- □ Difficulty Lying Flat
- □ Heart Attack
- □ Hypertension

Constitutional
- □ Fatigue / Weakness
- □ Fever
- □ Weight Gain / Loss

Respiratory
- □ Cough
- □ Congestion
- □ Wheezing
- □ Asthma
- □ Shortness of Breath

Gastrointestinal
- □ Heartburn
- □ Nausea / Vomiting
- □ Jaundice / Hepatitus

Genito-Urinary
- □ Pain / Difficulty
- □ Blood in Urine
- □ History of Kidney Stones
- □ History of STD's
- □ History of Prostate Issues
- □ Use of Flomax/Rapaflo

Psychiatric
- □ Anxiety / Depression
- □ Mood Swings
- □ Difficulty Sleeping

Endocrine
- □ Increased Thirst
- □ Increased Hunger
- □ Increased Urination
- □ Increased Sweating

Blood / Lymphnodes
- □ Easy Bruising
- □ Gums Bleed Easy
- □ Prolonged Bleeding
- □ Heavy Aspirin Use

MusculoSkeletal
- □ Stiffness
- □ Arthritis
- □ Joint Pain / Swelling

Skin
- □ Rash / Sores
- □ Lesions
- □ Hives / Eczema

Neurological
- □ Seizures
- □ Weakness / Paralysis
- □ Numbness
- □ Tremors

Immunologic
- □ Hives
- □ Itching
- □ Runny Nose
- □ Sinus Pressure

Busack Eye Center

Patient's Name _____ **Today's Date** _____

Date of Birth _____

Pre-Cataract Surgery - Visual Functioning Index (VF-8R) Patient Questionnaire

Do you have difficulty, even with glasses with the following activities?

1. Reading small print such as labels on medicine bottles, a telephone book or food labels?	☐ Yes	☐ No	☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A Little	☐ A Moderate Amount	
	☐ A Great Deal	☐ Unable to do the activity	
2. Reading a newspaper or book?	☐ Yes	☐ No	☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A Little	☐ A Moderate Amount	
	☐ A Great Deal	☐ Unable to do the activity	
3. Seeing steps, stairs or curbs?	☐ Yes	☐ No	☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A Little	☐ A Moderate Amount	
	☐ A Great Deal	☐ Unable to do the activity	
4. Reading traffic signs, street signs or store signs?	☐ Yes	☐ No	☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A Little	☐ A Moderate Amount	
	☐ A Great Deal	☐ Unable to do the activity	
5. Doing fine handwork like sewing, knitting, crocheting or carpentry?	☐ Yes	☐ No	☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A Little	☐ A Moderate Amount	
	☐ A Great Deal	☐ Unable to do the activity	
6. Writing checks or filling out forms?	☐ Yes	☐ No	☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A Little	☐ A Moderate Amount	
	☐ A Great Deal	☐ Unable to do the activity	
7. Playing games such as bingo, dominos, card games or mahjong?	☐ Yes	☐ No	☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A Little	☐ A Moderate Amount	
	☐ A Great Deal	☐ Unable to do the activity	
8. Watching television?	☐ Yes	☐ No	☐ Not Applicable
If yes, how much difficulty do you currently have?	☐ A Little	☐ A Moderate Amount	
	☐ A Great Deal	☐ Unable to do the activity	

Busack Eye Center

CATARACT/IOL EVALUATION

Patient's Name _____ **Age** _____ **Date** _____

CATARACT EFFECT AND VISION PROBLEMS (please check all that apply)

☐ Glare Problems ☐ Trouble driving at night

☐ Trouble seeing in bright sun light ☐ Blurred vision

☐ Difficulty reading

Do you drive at night? ☐ Seldom ☐ Often ☐ Do not drive

Do you have Diabetes? YES / NO ☐ Insulin ☐ Oral Medication

Do you take any Blood Thinner? ☐ Coumadin ☐ Plavix ☐ Aspirin ☐ none

Treatment for Urinary Conditions:
(Circle or list those taken currently **OR** in the past)

Flomax / Avodart / Tamsulosin HCL / Hytrin
Terazosin / Carcura / Doxzaosin
Uroxatral / Alfuzon / Sanofiaventis
Saw Palmetto (an Herbal Supplement)
_____
_____

Would you prefer to limit or reduce your use of glasses? YES / NO

Do you prefer to wear glasses to correct you vision? YES / NO

Are you willing to pay extra for a specialty lens or procedure, that is **NOT** covered by **ANY** insurance, to reduce your dependence on glasses? YES / NO

Work / Occupation _____Computer Work _____hours per day

Do you exercise or perform strenuous activity on a regular basis? YES / NO

If Yes, how often? _____

ACTIVITIES/HOBBIES (circle) Crafts Reading TV Sports Golf

_____ _____
Patient's signature Date

I authorize _____to be present during this visit.

James A. Busack EyeMD LLC
470 W. Patrick St.
Frederick, MD 21701

BusackEye.com
P: 301.668.2020
F: 301.620.8729

Busack Eye Center

Please review carefully. you will be asked to sign electronically upon arrival in the office.

PATIENT CONSENTS, ACKNOWLEDGEMENTS AND AUTHORIZATIONS

I voluntarily consent to such care and treatment as prescribed by the physician as is necessary in his judgment.

FINANCIAL POLICY

We are dedicated to providing you with the best possible care and service, and we regard your understanding of our financial policies as an essential element of our service to you. Our policies regarding various financial matters are stated below. If you have questions, please feel free to discuss them with our staff.

PAYMENT DUE AT SERVICE: Unless other arrangements have been made in advance by either yourself or your health coverage carrier, full payment is due at the time of service.
YOUR INSURANCE: We will be happy to submit claims to any insurance plan in which we participate, however, any copayment/coinsurance is due at the time of service. In the event your health plan determines a service to be "not covered," you will be responsible for the complete charge. In that event, we will bill you and payment will be due upon receipt of that statement. In the event we do not participate with your insurance, you are responsible for full payment at the time of service.
MINOR PATIENTS: For all services rendered to minor patients, the adult accompanying the patient is responsible for payment.
POWER OF ATTORNEY: If you are signing this Patient Registration Form pursuant to a Power of Attorney (often part of an Advance Medical Directive) that the patient has granted you, you must provide us with a copy of the Medical Power of Attorney which clearly authorizes you to seek treatment for the patient.
RETURNED CHECKS AND MISSED APPOINTMENTS: It is our office policy to charge a fee of $50.00 for any returned checks and for any missed appointment without a 24-hour cancellation notice.
DELINQUENT ACCOUNTS: Interest at the rate of 12% per annum will be charged on accounts with balances over 90 days old. Additionally, you will be liable for all reasonable collection fees, including attorney's fees and court costs incurred as a result of your delinquency. By signing below, I understand and agree that information related to my medical history may be sent to collection agencies or financial institutions should my account become delinquent.

CONSENT FOR 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 is best if you make arrangements not to drive yourself.

I hereby authorize Dr. James A. Busack and/or such assistants as may be designated by him to administer eye drops, if they determine the eye drops are necessary to diagnose my condition. I understand that sunglasses are recommended after eye dilation and are available at the front desk from the receptionist and should be obtained upon check out.

PATIENT AUTHORIZATION AND ASSIGNMENT

I hereby authorize Dr. James A. Busack to apply for benefits on my behalf for covered services rendered. I assign to Dr. James A. Busack, and I request that my insurance company pay directly to Dr. James A. Busack, all medical and/or surgical benefits to which I am entitled, including major medical benefits, Medicare, private insurance and other health benefits. I certify that the information I have reported with respect to my insurance coverage is correct and further authorize Dr. James A. Busack to release any necessary information regarding my illness, treatment and/or services rendered to my insurance carriers, other medical professionals who are collaborating in my care. **Payment for all professional services rendered is the responsibility of the patient, parent or guardian. By signing below, I understand and agree that I am financially responsible for all charges regardless of insurance coverage. Thus, if my insurance requires a referral and I do not provide a properly completed referral, I understand that I am responsible for the full amount of all charges. In addition, I authorize Dr. James A. Busack to release any medical information regarding my treatment and services rendered in order to collect on a delinquent account.**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (as regulated by HEALTH INFORMATION PROTABILITY AND ACCOUNTABILITY ACT - HIPAA)

I have been advised the Notice of Privacy Practices may be found on the Busack Eye Center website, **busackeye.com,** or upon request I was provided a copy of the Notice of Privacy Practices for the office of Dr. James A. Busack, Eye, M.D.

I authorize the practice of Dr. James A. Busack to disclose certain protected health information (PHI) about me to the party or parties listed below (e.g., Spouse, other relatives or friends)

First and Last Name **Relation**

_____

_____

_____

I acknowledge that when my PHI is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

I have the right to revoke this PHI disclosure authorization in writing except to the extent that the practice of Dr. James A. Busack has acted in reliance on the authorization. My written revocation must be submitted to Dr. James A. Busack's Privacy Officer at 470 West Patrick Street, Frederick, MD 21701.