



# Busack Eye Center

## PATIENT REGISTRATION FORM

Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Preferred 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 #: \_\_\_\_\_

**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:**

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**Past Eye History: (Please mark all that apply)**

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

**Eye Surgeries: (Please mark all that apply)**

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

Surgeon? \_\_\_\_\_ Date \_\_\_\_\_ Which eye? Right / Left

**Eye Illnesses: (Please mark all that apply)**

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

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

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**History of Illnesses:**

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

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

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

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**Current Other Medications: (Please list or attach list)**

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**Flomax or medication for Prostate issues (please list)** \_\_\_\_\_

**Infections: (Please mark all that apply)**

- |  |   |                                     |  |
|--|---|-------------------------------------|--|
| <input type="checkbox"/> Overall Healthy     | <input type="checkbox"/> Herpes Simplex           | <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Syphilis        |
| <input type="checkbox"/> Chicken Pox         | <input type="checkbox"/> Herpes Zoster / Shingles | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Toxoplasmosis   |
| <input type="checkbox"/> Hepatitis A / B / C | <input type="checkbox"/> Histoplasmosis           | <input type="checkbox"/> MRSA       | <input type="checkbox"/> Wound Infection |

Other \_\_\_\_\_

**Family History:**

- |  |   |                                    |   |   |
|--|---|------------------------------------|---|---|
| <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Stroke         | <input type="checkbox"/> Blindness | <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Arthritis          |
| <input type="checkbox"/> Cancer        | <input type="checkbox"/> TB             | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Retinal Disease      | <input type="checkbox"/> Lazy Eye           |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Glaucoma  | <input type="checkbox"/> High Blood Pressure  | <input type="checkbox"/> 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 / Hepatitis

**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

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?

<b>1. Reading small print such as labels on medicine bottles, a telephone book or food labels?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Applicable
If yes, how much difficulty do you currently have?	<input type="checkbox"/> A Little	<input type="checkbox"/> A Moderate Amount	
	<input type="checkbox"/> A Great Deal	<input type="checkbox"/> Unable to do the activity	
<b>2. Reading a newspaper or book?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Applicable
If yes, how much difficulty do you currently have?	<input type="checkbox"/> A Little	<input type="checkbox"/> A Moderate Amount	
	<input type="checkbox"/> A Great Deal	<input type="checkbox"/> Unable to do the activity	
<b>3. Seeing steps, stairs or curbs?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Applicable
If yes, how much difficulty do you currently have?	<input type="checkbox"/> A Little	<input type="checkbox"/> A Moderate Amount	
	<input type="checkbox"/> A Great Deal	<input type="checkbox"/> Unable to do the activity	
<b>4. Reading traffic signs, street signs or store signs?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Applicable
If yes, how much difficulty do you currently have?	<input type="checkbox"/> A Little	<input type="checkbox"/> A Moderate Amount	
	<input type="checkbox"/> A Great Deal	<input type="checkbox"/> Unable to do the activity	
<b>5. Doing fine handwork like sewing, knitting, crocheting or carpentry?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Applicable
If yes, how much difficulty do you currently have?	<input type="checkbox"/> A Little	<input type="checkbox"/> A Moderate Amount	
	<input type="checkbox"/> A Great Deal	<input type="checkbox"/> Unable to do the activity	
<b>6. Writing checks or filling out forms?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Applicable
If yes, how much difficulty do you currently have?	<input type="checkbox"/> A Little	<input type="checkbox"/> A Moderate Amount	
	<input type="checkbox"/> A Great Deal	<input type="checkbox"/> Unable to do the activity	
<b>7. Playing games such as bingo, dominos, card games or mahjong?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Applicable
If yes, how much difficulty do you currently have?	<input type="checkbox"/> A Little	<input type="checkbox"/> A Moderate Amount	
	<input type="checkbox"/> A Great Deal	<input type="checkbox"/> Unable to do the activity	
<b>8. Watching television?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Applicable
If yes, how much difficulty do you currently have?	<input type="checkbox"/> A Little	<input type="checkbox"/> A Moderate Amount	
	<input type="checkbox"/> A Great Deal	<input type="checkbox"/> 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: Flomax / Avodart / Tamsulosin HCL / Hytrin  
(Circle or list those taken Terazosin / Carcra / Doxzaosin  
currently **OR** in the past) 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.

**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 PRIVACY 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**

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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.