Cullom & Farah
EYE & LASER CENTER
A Division of Riverside Medical Group

PATIENT REGISTRATION FORM

Name:_____ Social Security #:_____
(Last) (First) (M.I.)

Mailing Address:_____
(Street or PO Box Number & Name) (City) (State) (Zip Code)

Birthdate:_____/_____/_____ Age:_____ Sex: Male / Female Race/Ethnicity:_____

Marital Status: S / M / D / W Interpreter Needed? Yes or No

Home Phone:_____ Work Phone:_____ Cell Phone: _____

Preferred number called first:_____

In case of emergency, name of contact: _____ Phone #: _____

Employer:_____Occupation:_____

Primary Care Physician:_____ Phone #:_____

Optometrist (If outside our office):_____ Phone #:_____

Whom may we thank for referring you?:_____ Phone #:_____

Email Address:_____

Would you like to sign up for Riverside Online MYCHART?: Yes or No

Patient Agreement

A refraction is a diagnostic test used to determine the patient's visual abilities. A series of lenses are presented to determine which prescription provides the sharpest and clearest vision. This test is performed during your annual eye exam or if there has been a recent change in your vision. It is necessary for the physician to perform this test in order to determine the best visual acuity, as well as, evaluate potential eye diseases. **Some insurance companies, including MEDICARE, do not cover the refraction test.** The usual charge for this service is $55. If your insurance does not cover this test, Cullom Eye & Laser Center offers a time-of-service discount of $20.00 Therefore, if you pay today, your out-of-pocket expense is only $35. If you cannot pay today, your charge will be sent through our billing service and you will be billed for the full fee of $55.

Initials: _____ Date: _____

Initials: _____ Date: _____

Appointments

I understand that I may be given a return appointment in order to follow-up on my eye status or condition. In the event that, for any reason, I do not keep that appointment and do not promptly reschedule, I agree not to hold Cullom & Farah Eye & Laser Center, it's Physicians, and/or staff responsible for any resulting consequences. Appointments cancelled with less than 24 hours' notice may be charged to my account.

I understand that if I arrive more than 15 minutes past my appointment time, it may result in rescheduling my appointment due to clinic flow.

Initials: _____ Date: _____

Notice of Privacy Practices

I am aware of and/or have received Riverside's Notice of Privacy Practices brochure. Upon receiving an inquiry as to the presence or condition of the Patient, RMG may (unless otherwise requested by the Patient, next of kin, or physician) release at its discretion; the name, address, age, sex, general nature of injuries, and/or the general condition of the Patient. I understand that a separate written consent is required for me and/or I the person(s) listed below to receive copies of my written medical records. However, I hereby give permission to my physician & office personnel to verbally discuss any and all of my medical condition(s) with the following person(s).

Please list someone besides yourself if you want your medical information shared.

Print Individual Name & Phone Number

Print Individual Name & Phone Number

Print Individual Name & Phone Number

Print Individual Name & Phone Number

Medical History

Patient Name: **Birthdate:** _____/_____/_____

Are you having problems with any of the following activities? O Driving O Computer O Night driving O Seeing halos O Reading traffic signs O Crossword puzzles O Watching TV O Hazy vision O Problems from glare O Fine print O Other:_____

List any past eye injuries, surgeries, or problems: _____
_____

Alcohol Consumption: O Never O Socially O Moderate O Heavy **Smoking:** O Yes O No

Family History: (grandparents, parents, brother, sister, children) O Glaucoma O Cataracts O Diabetes O Lazy eye O Macular degeneration O Strabismus O Cancer

MEDICATION / GLASSES & CONTACT LENSES

Do you currently wear glasses? O Yes O No

Do you currently wear contact lenses? O Yes O No

Please list any allergies (Foods, medications, latex, anesthesia):

_____

_____

Please circle the following conditions if they pertain to you:

Fever/Weight Loss Diabetes/Thyroid Heart Problems High Blood Pressure Asthma/Emphysema

Circulation Problems Hepatitis/HIV/AIDS Neurological (MS) Blood or Lymph Cholesterol

Anxiety/Depression Kidney/Bladder Cancer Muscle/Joint Sleep Apnea Pregnant/Nursing

Skin Condition Other If yes, please give details to your conditions:_____

_____

_____

Patient Name: _____ **Birthdate:** _____/_____/_____

Have you EVER taken any of the following medications? If yes, please list information below:

Please list your medications:

Name of medication	Dosage	Frequency

Have you received the Pneumovax? (Please circle) YES / NO If so, when?_____

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