WALSH EYE

PATIENT REGISTRATION INFORMATION

Please Print

Dr. Mrs. Ms. Mr. First Name_____ M.I._____ Last_____

Sex: M F SS#_____ Date of Birth_____/_____/_____ Age_____

Marital Status: Married Single Divorced Widowed If married, spouse's name:_____

Mailing Address_____ Email_____

City_____ State_____ Postal Code_____

Home Phone (_____)_____ Cell Phone(_____)_____

Race:_____ Occupation_____

Employer_____ Work Phone (_____)_____

Emergency Contact: Name_____Phone(_____)_____Relationship_____

INSURANCE INFORMATION

If you would like us to file claims with insurance, please fill out the section below. **You may be required to obtain a referral** (and keep it up to date) from your primary care physician before insurance will pay for an exam with Dr. Walsh. While it is the responsibility of the patient to obtain referral authorization before their visit, our office will do everything possible to obtain the referral for you if you have not done so already. Per the contract between you and your insurance company, you will be responsible for any charges if a referral cannot be obtained and your insurance company denies payment.

Primary Insurance_____ HMO_____ PPO_____ Other_____

Subscriber's Name_____ Subscriber's DOB _____/_____/_____

Subscriber's SS#_____

Secondary Insurance_____ HMO_____ PPO_____ Other_____

Subscriber's Name_____ Subscriber's DOB_____/_____/_____

Subscriber's SS#_____

Vision Insurance _____

LIFETIME BENEFICIARY CLAIM AUTHORIZATION AND COLLECTION POLICY

I request that payment of authorized Medicare Benefits be made on my behalf to Max T. Walsh, M.D., P.C. for any services furnished to me by Max T. Walsh, M.D., P.C. I authorize any holder of medical information about me to release to the Health Care Funding Administration and its agents any information needed to determine these benefits payable related services. I understand my signatures requests that payment be made any authorizes release of medical information necessary to pay a claim. If other insurance coverage is indicated in item 9 of HCFA 1500 claim form or elsewhere on other approved claims forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or suppliers agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based on the charge determination of the carrier. I accept responsibility for all charges not otherwise covered by my insurance company or other payor.

If you do not have coverage for a particular service or have co-payments or annual deductibles, payment is due at the time of service unless other arrangements have been made with the office prior to the treatment. After monthly bill is sent and if balance is not paid appropriate late fees will be applied and can be submitted to a collection agency.

Signature (Patient or Parent if Minor)

Date

_____ _____

Acknowledgement of Receipt of Notice of Privacy Practices

By signing below I acknowledge that I have been offered or received a copy of this office's Notice of Privacy Practices.

Patient signature_____ Date_____

Documentation of failure to obtain signed acknowledgement

On_____, 20____, the office of Max T. Walsh, M.D., P.C. presented this Acknowledgement to Receipt of Notice of Privacy Practices form to_____ (the "Patient"). The Patient declined to provide a signature.

WALSH EYE

EYE HISTORY

NAME:_____ DATE: _____

DATE OF LAST EYE EXAM? _____

Do you currently wear glasses? Yes _____ No_____

If YES, how long have you had your current prescription?_____

If YES, where do you purchase your glasses?_____

Have you ever tried to wear contacts? Yes _____No _____

If YES, where do you purchase your contacts?_____

Do you have problems with reading? Yes_____ No _____

Does your vision prevent you from doing any of your normal daily activities? Yes_____ No_____

If YES, please describe:_____

Do you have problems with driving at night? Yes_____ No_____

Are you currently experiencing any eye symptoms? Please circle all that apply:

Loss of Vision	Blurred Vision	Distorted Vision (halos)	Double Vision
Loss of Side Vision	Dryness	Mucous Discharge	Burning
Sandy/Gritty Feeling	Foreign Body Sensation	Excessive Tearing/Watering	Occasional Tearing
Itchy	Glare/Light Sensitivity	Chronic Infection of eye/lid	Sties, Chalazion
Eye Pain/Soreness	Fluctuating Visual Activity	Redness	Tired Eyes

History of Vision Problems? Please circle all that apply: No Previous History Glaucoma Cataracts Dry Eyes

Diabetic Retinopathy Retinal Tear/Detachment Keratoconus Strabismus

Herpes Simplex/Zoster Amblyopia/Lazy Eye Corneal Abrasion Trauma/Foreign Body/Scar Recurrent Erosion

Other _____

History of Eye Surgery No Previous History_____ LASIK/PRK/ASA _____ RK/AK_____ Cataract _____

Muscle_____ Retinal_____ Corneal Transplant_____ Other_____

History of eye injury? Please describe:_____

Does your vision prevent you from doing of your normal daily activities?_____

Eye medications? Please list the name and how often used._____

_____

Family history of eye problems? Please circle and list family relationship:

Blindness_____Cataract_____Glaucoma_____Macular Degeneration_____ Retinal

Detachment_____

Family Medical History: Do you know of any blood relatives who have or had the following conditions? Diabetes Thyroid disease

Heart disease High blood pressure Pituitary disease Cancer Stroke Other significant illnesses, list: _____

For the Doctor to fill out

History reviewed: _____ No Changes _____ Additions as note above

Doctor's signature: Max T. Walsh, MD Christopher R. Walsh OD FAAO Date: _____

Max T. Walsh, M.D./ Christopher R. Walsh O.D., FAAO

WALSH EYE

MEDICAL HISTORY QUESTIONAIRE

Name:_____ Birth Date:_____ Height:_____ Weight:_____lbs

Name of referring physician:_____ Physician Phone: (____)_____

Physician Address:_____

Past Surgeries: (LIST)_____

Allergy to Medications Yes No If yes List:_____

Women only: Are you currently pregnant or breastfeeding? Yes No

REVIEW OF SYSTEMS: Please circle any of the following symptoms or problems that are **currently being treated for or have been treated for in the past**

Constitutional:____No symptoms or problems. Fatigue Fever Loss of appetite Night sweats Weakness Weight gain or loss

Ear/Nose/Throat:_____ No symptoms or problems. Dry mouth Earaches Hearing loss Mouth sores Nasal discharge Sinus problems Smell disturbance Sore throat Ringing in ears Vertigo/dizziness

Cardiovascular:_____ No symptoms or problems. High Blood Pressure Chest pain High Cholesterol Irregular heart beats Palpitations Rheumatic Fever Atrial Fibrillation

Respiratory:____No symptoms or problems. Asthma Bronchitis Chronic cough Emphysema Pneumonia Tuberculosis

Gastrointestinal:____ No symptoms or problems. Nausea or vomiting Stomach ulcer Painful bowl/constipation Abdominal pain or heartburn

Genitourinary:____No symptoms or problems Frequent urination Urinary infections Kidney stones Pain Painful urination Excessive urination Sexual difficulties Sexually transmitted disease

Muscular/Skeletal:____No symptoms or problems. Arthritis Gout Joint pain

Integumentary:____ No symptoms or problems Breast cancer Dermatitis Dry skin Eczema Skin cancer Skin tumors

Neurological:___No symptoms or problems. Headache Migraines Memory loss Numbness Stroke Seizures Dementia Parkinson's

Psychiatric:____No symptoms or problems. Anxiety Depression Hallucinations Nervousness

Endocrine:____No symptoms or problems. Diabetes Hyperthyroid Hypothyroid

Hematologic/Lymphatic: ___No symptoms/problems. Anemia HIV

Allergies/Immunologic:____No symptoms or problems Hay fever Seasonal Allergies

Social History

Smoke? Yes No If yes, ___ packs/day for ___ years. **Recreation drugs?** Yes No **Blood transfusions?** Yes No

Drink? Yes No If yes, how much_____ **Do you have AIDS, HIV or Hepatitis?** Yes_____ No_____

Have you ever been intimate contact with a person who had a sexually transmitted disease? Yes_____ No_____

INFORMATION REGARDING DILATING EYE DROPS AND CONSENT TO TREAT

Dilating eye drops are used to enlarge the pupil of the eye to allow the eye doctor to get a better view of the inside of your eye. These drops frequently blur your vision for a length of time which varies for each person and may make bright lights bothersome. It is not possible for your eye doctor to predict how much your vision will be affected.I have requested medical services from Walsh Eye for me or my child. I agree to and understand that my/my child's eyes may be dilated in order for the doctor to thoroughly check the nerve and retina. I understand that if my pupils are dilated, I may not be able to safely operate a motor vehicle and that the staff and doctors of Walsh Eye recommend that I find alternate transportation. I hereby authorize Dr. Walsh and/or their assistants, which may be designated by them, to administer dilating eye drops. These drops are necessary to diagnose my condition, if any exists.

Patient Signature_____ Date_____

WALSH EYE

PERSONAL MEDICATION RECORD

Name: _____ Date of Birth:_____
Primary Care Physician: _____ Phone: _____
Pharmacy: _____ Phone: _____
Allergies: _____

Medication (Prescriptions, over-the-counter, eye drops, supplements)	**Dosage** (mg, units, drops)	**How and How Often Do You Take This Medication** (Example: three times a day, at night)	**Reason For taking**