Center For Vitreo Retinal Diseases SC

9301 West Golf Road
Suite 102
Des Plaines, IL 60016-1600
USA
(847) 294-0080

PATIENT INFORMATION

NAME (Last, First Middle)		MRN	SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	CITY, STATE ZIP	REFERRING PHYSICIAN	SECONDARY/BILLING ADDRESS	ETHNICITY

HOME PHONE	DAY PHONE	EMAIL ADDRESS	PRIMARY CARE PROVIDER	CITY, STATE ZIP	RACE

MARITAL STATUS	STUDENT STATUS	SMOKER (Y/N)?	VETERAN (Y/N)?	EMERGENCY CONTACT NAME	CONTACT PHONE	HOME PHONE
	☐ Full-Time ☐ Part-Time					

SEXUAL ORIENTATION	PREFERRED PRONOUN	GENDER IDENTITY	

PRIMARY EMPLOYER	SECONDARY EMPLOYER (if Applicable)
ADDRESS	ADDRESS
CITY, STATE ZIP	CITY, STATE ZIP
WORK PHONE	WORK PHONE

RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)		SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	CITY, STATE ZIP	SECONDARY/BILLING ADDRESS (if Applicable)

HOME PHONE	DAY PHONE	EMAIL ADDRESS	CITY, STATE ZIP

MARITAL STATUS	STUDENT STATUS	SMOKER (Y/N)?	VETERAN (Y/N)?	PRIMARY CARE PROVIDER	HOME PHONE
	☐ Full-time ☐ Part-time				

RELATIONSHIP TO PATIENT	

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY		POLICY#	

NAME OF INSURED	GROUP#

ADDRESS OF INSURANCE COMPANY	COPAY AMT
	$

CITY, STATE ZIP	PHONE	DEDUCTIBLE
		$

RELATIONSHIP TO PATIENT	EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY		POLICY#	

NAME OF INSURED	SSN#	BIRTHDATE	GROUP#

ADDRESS OF INSURANCE COMPANY	COPAY AMT
	$

CITY, STATE ZIP	PHONE	DEDUCTIBLE
		$

RELATIONSHIP TO PATIENT	EFFECTIVE DATE	EXPIRATION DATE

SIGNATURE OF PATIENT/GUARDIAN _____ DATE _____

CENTER FOR VITREO RETINAL DISEASES
DR. IRA GAROON & DR. ROBERT GAROON

Patient Name:_____ **Date of Birth:**_____

Pharmacy Name/Location:_____

PAST MEDICAL HISTORY

Have you been diagnosed or told of having any of the following?

	YES	NO	WHEN DIAGNOSED & CURRENT TREATMENT:
Heart Disease	☐	☐	
High Blood Pressure	☐	☐	
High Cholesterol	☐	☐	
Diabetes	☐	☐	
Respiratory	☐	☐	
Urological/Gastro	☐	☐	
Cancer	☐	☐	
Stroke/Neurological	☐	☐	
Blood Disorders/Disease	☐	☐	
Arthritis/Osteoporosis	☐	☐	
Skin Disease/Disorder	☐	☐	
Other Medical Condition	☐	☐	

Are you taking any medications? YES☐ NO☐
If YES, please list medications on Medication List provided (last page provided)

Have you had any surgeries? YES☐ NO☐
If YES, please list type and when:_____

Do you have any allergies? YES☐ NO☐
If YES, please indicate allergy and reaction:_____

Have you had the Influenza Immunization: YES☐ NO☐ Date received:_____

Have you had the Pneumococcal Vaccination: YES☐ NO☐ Date received: _____

Name:_____ Date:_____ page 2

PAST OCULAR HISTORY

Have you been diagnosed or told of having any of the following?

	YES	NO	WHICH EYE:
Cataracts	☐	☐	_____
Glaucoma	☐	☐	_____
Other Eye Condition	☐	☐	_____

Have you had any eye surgery? If YES, please indicate surgery, date and surgeon below?

Left Eye:_____Date/Surgeon_____

Right Eye:_____Date/Surgeon_____

Please list any eye drops you are currently using: (name and frequency)

Left Eye:_____

Right Eye:_____

Do you wear glasses or contacts? YES☐ NO☐

If YES, type and for how long:_____

SOCIAL HISTORY

Marital Status: Single☐ Married☐ Divorced☐ Widowed☐

Race: ☐White ☐African American ☐Asian ☐Pacific Islander ☐Native American ☐Multiracial

Ethnicity: ☐Hispanic ☐Non-Hispanic ☐Patient Declines

Do you work? YES☐ NO☐ RETIRED☐

If YES, type of work:_____

Do you have children? YES☐ NO☐

If YES, how many:_____

Do you drink alcohol? YES☐ NO☐

If YES, Amount & Frequency:_____

Do you currently smoke? YES☐ NO☐

If YES, amount per day:_____

Former smoker? YES☐ NO☐

If YES, date you quit:_____

Do you use caffeine? YES☐ NO☐

If YES, how many cups per day:_____

Any history of drug abuse? YES☐ NO☐

If YES, indicate type:_____

FAMILY HISTORY

Any medical or eye conditions in your family? YES☐ NO☐

Disease	YES	NO	Relationship to patient and which side paternal/maternal
Macular Degeneration	☐	☐	
Retinal Detachment	☐	☐	
Cataracts	☐	☐	
Glaucoma	☐	☐	
Diabetes	☐	☐	
Heart Disease	☐	☐	
Cancer	☐	☐	
Other Medical condition	☐	☐	

Patient Signature/Date:_____

Physician signature: Ira Garoon, M.D._____

Physician signature: Robert Garoon, M.D._____

Please list all medications, vitamins and herbal supplements

Medication Drug, Vitamin, Herb or OTC	Dosage Dose Amount	Frequency How Often	Route Pill, Drop, Shot

CENTER FOR VITREO RETINAL DISEASES

DR. IRA GAROON & DR. ROBERT GAROON

9301 W. Golf Rd #102
Des Plaines, IL 60016
847-294-0080

1880 W. Winchester Rd #203
Libertyville, IL 60048
847-247-1164

PATIENT ASSIGNMENT OF BENEFITS
&
RECEIPT OF PRIVACY NOTICE

MANAGED CARE PATIENTS

I am aware of all restrictions and guidelines enforced by my insurance plan.
I understand each service must be pre-authorized and that obtaining the authorization is my responsibility.
Without proper authorization, I understand that payment may be required at the time of service.
Patient Initials: _____

ASSIGNMENT OF BENEFITS

I hereby assign payment to Center for Vitreo Retinal Diseases, S.C. for medical and/or surgical benefits otherwise payable to me for all services rendered. I understand that I am responsible for all charges.

_____ _____

Signature of Patient or Legal Guardian Date

ACKNOWLEDGEMENT OF RECEIVE OF NOTICE OF PRIVACY POLICIES:

I acknowledge receipt of the Notice of Privacy Policies for Center for Vitreo Retinal Diseases, S.C., as pertaining to my protected health information. My signature below indicates my consent for the use and disclosure of my information as outlined in the notice. It further allows for the release of my information for the purpose of carrying out treatment, payment, health care operations, and law enforcement. I may revoke this consent in writing at any time; it remains valid until I do so.
The practice reserves the right to modify the policies outlined in the notice; a copy of the modified notice will be provided to me or available for my review.

_____ _____

Signature of Patient or Legal Guardian Date

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DR. IRA GAROON & DR. ROBERT GAROON

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Des Plaines, IL 60016
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Libertyville, IL 60048
847-247-1164

A copy of your chart note will be sent to your primary care physician on file and your referring physician on file. If you wish to have these records sent to any other physician, please provide the following:

Physician Name_____

Physician Address_____ City, State, Zip_____

Telephone Number_____ Fax Number_____

Physician Name_____

Physician Address_____ City, State, Zip_____

Telephone Number_____ Fax Number_____

Physician Name_____

Physician Address_____ City, State, Zip_____

Telephone Number_____ Fax Number_____

Patient Signature _____