CENTER FOR VITREO RETINAL DISEASES

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1880 W. Winchester Rd. #203

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847-247-1164

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Thank you for choosing Center for Vitreo Retinal Diseases

Please bring the completed paperwork to your appointment - DO NOT mail the paperwork back to us.

Please bring your insurance cards and photo ID on the day of your appointment.

If you have an HMO for insurance, you MUST have a referral form in order for us to see you. If you do not have a copy of the referral and it is being sent directly to us, please make sure your we have received it prior to your appointment by calling to confirm we have it.

Your copay will be collected at the time of your visit.

Due to the nature of your visit to an ophthalmology specialist, please plan on being at your appointment approximately 1.5 hours.

CENTER FOR VITREO RETINAL DISEASES

PATIENT INFORMATION

Last name First Name Middle Initial SSN Date of Birth Sex

_____ _____ M___ F___

Address City, State, Zip Marital Status

_____ _____ Single___Married___Other___

Home Phone Number Cell Phone Number Email

_____ _____ _____

Emergency Contact Name Phone Number Relationship

_____ _____ _____

INSURANCE INFORMATION

PRIMARY INSURANCE

Name of Insurance Company POLICY#

_____ _____

Address of Insurance Company GROUP#

_____ _____

City, State, Zip Code Relationship to Patient

_____ Self____ Spouse____ Parent_____

SECONDARY INSURANCE

Name of Insurance Company POLICY#

_____ _____

Address of Insurance Company GROUP#

_____ _____

City, State, Zip Code Relationship to Patient

_____ Self____ Spouse____ Parent_____

I authorize the release of information to insurance carriers and/or other healthcare providers as may be necessary to file a claim or facilitate my health care. I assign payment of benefits to Center for Vitreo Retinal Diseases, S.C. or provider indicated on the claim. I understand I am financially responsible for any balance not covered by my insurance carrier

Patient Name_____ Date of Birth_____

Primary Care Physician	Phone Number	Address
_____	_____	_____
Doctor that Referred You to Us	Phone Number	Address
_____	_____	_____
Pharmacy Name	Town/City	Cross Streets Near Pharmacy
_____	_____	_____

Do You Have Any Allergies _____yes _____no If yes please list all allergies

_____

Smoking History Do you currently smoke _____yes _____no

Have you ever smoked _____ yes _____no If yes when did you quit_____

Do you drink alcohol _____yes _____no If yes how often ie daily, weekly, socially_____

Ocular History

Do you wear glasses? _____ yes _____no Do you wear contact lenses? _____yes _____no

Are you currently using any eye drops _____yes _____no If yes, list them below

Name of drop_____ how often_____ which eye_____

Name of drop_____ how often_____ which eye_____

Have you had any eye surgery? _____yes _____no If yes, list below

Surgery performed_____ Which Eye_____

Date of Surgery_____ Surgeon_____

Have you ever been diagnosed with any of the following?

Glaucoma _____yes _____no

Cataracts _____yes _____no

List any other eye condition you have_____

Patient Name_____ Date of Birth_____

Medical History

Have you been diagnosed with any of the following:

Diabetes	_____ yes	_____no	Respiratory Disease	_____ yes	_____no
Heart Disease	_____ yes	_____no	Blood Disorder	_____ yes	_____no
High Blood Pressure	_____ yes	_____no	Urological/Gastro Disease	_____ yes	_____no
High Cholesterol	_____ yes	_____no	Cancer	_____ yes	_____no
Stroke	_____ yes	_____no	Respiratory Disease	_____ yes	_____no
Arthritis	_____ yes	_____no	Skin Disease	_____ yes	_____no

List any Other Medical Condition _____

Family Medical History

Has any family member been diagnosed with any of the following conditions?

If yes, indicate mother or father

Macular Degeneration	_____Mother's side	_____Father's side
Retinal Detachment	_____Mother's side	_____Father's side
Cataracts	_____Mother's side	_____Father's side
Glaucoma	_____Mother's side	_____Father's side
Diabetes	_____Mother's side	_____Father's side
High Blood Pressure	_____Mother's side	_____Father's side
Heart Disease	_____Mother's side	_____Father's side
Cancer	_____Mother's side	_____Father's side
Stroke	_____Mother's side	_____Father's side

Patient Name_____ Date of Birth_____

Are you taking a GLP1 _____yes _____no

If yes, please provide the name of the GLP1_____

Please list all medications and vitamins you are currently taking

Medication/Vitamin/Supplement Name	Dosage (Example 20mg)	How often do you take it (Example twice daily)

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DR. IRA GAROON & DR. ROBERT GAROON

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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