

**ROBERT W. JONES, M.D.**  
**PATIENT REGISTRATION FORM**

**Patient name** \_\_\_\_\_ **Female** **Male**  
Last First Middle.

**Address** \_\_\_\_\_ **S.S. No** \_\_\_\_\_  
Street City State Zip

**Home phone**( ) - \_\_\_\_\_ **Work Phone** \_\_\_\_\_ **Referring Dr.** \_\_\_\_\_  
area code

**Birthdate** - - \_\_\_\_\_ **Age** \_\_\_\_\_ **Marital status (circle)** M S D W  
Mo Day Yr

**Employer** \_\_\_\_\_ **Address** \_\_\_\_\_ **Ph. No.** \_\_\_\_\_

**Responsible for Payment:** Patient \_\_\_\_\_ Insurance \_\_\_\_\_ Other \_\_\_\_\_

If other (explain) \_\_\_\_\_

**Emergency Contact** \_\_\_\_\_ **Phone#** \_\_\_\_\_

**Spouse** \_\_\_\_\_ **Employer** \_\_\_\_\_ **Phone#** \_\_\_\_\_

**ALLERGIES (ALL)** \_\_\_\_\_

**A copy of your Medicare card and/or any other insurance card(s) pertaining to charges for this visit is required. Please have the card(s) ready when you return this form.**

All professional **services** rendered are **charged directly to the patient**. We will gladly file your insurance for you unless otherwise instructed. **Dr. Jones is a participant of the Medicare program and accepts whatever Medicare approves.** In cases of advised or **necessary treatment, without knowledge of Medicare/Insurance coverage,** you will be asked to sign a form **authorizing treatment and acknowledging responsibility of payment.** If you have questions, please ask.

**I hereby consent to any insurance carrier including Medicare and Medigap to release any information regarding the status of my claim(s) directly to Robert W. Jones, M.D.**

**I hereby authorize Robert W. Jones, M.D. to furnish information to my insurance carrier(s) my medical history, illness and treatment. I authorize my insurance benefits including Medicare and Medigap to be paid directly to Robert W Jones, M.D. I authorize Dr. Jones to release all information necessary to insure payment of these benefits.** A photocopy of this assignment may be considered valid as the original. This assignment will remain in effect until revoked in writing by myself.

**I HAVE READ AND UNDERSTAND THE ABOVE**

**SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

**REVIEW OF SYSTEMS**

**Dr. Jones** is a medical doctor who specializes in **ophthalmology**. Please **complete** this form and answer **ALL** questions. Your response may provide the doctor with pertinent information to better diagnose and treat your condition. *All information is confidential and will remain in your office chart.*

NAME \_\_\_\_\_ Emergency Contact \_\_\_\_\_

**PLEASE MARK YES OR NO ON ALL QUESTIONS!!**

**YOUR GENERAL HEALTH**

CONDITION	Yes	No	HOW LONG?	LIST ALL MEDICATIONS	DOSAGE
DIABETES (circle) diet, oral, insulin					
HEART CONDITION					
BLOOD PRESSURE					
STROKE					
RECENT(unwanted) WEIGHT LOSS					
ULCER, STOMACH DISORDERS					
SINUS PROBLEMS / INFECTIONS					
ARTHRITIS					
SKIN CANCERS, PSORIASIS etc.					
DEPRESSION, NERVE DISORDER					
ANEMIA, BLOOD DISORDER					
ASTHMA / RESPIRATORY					
T.B., H.I.V., OTHER INFECTIOUS					
OTHER					

**ALLERGIES:** \_\_\_\_\_  
 (drug & other) \_\_\_\_\_

**HOW DID YOU HEAR ABOUT US?** \_\_\_\_\_

**OFFICE USE ONLY**

			TECH	DATE	DR.
ECCEciOL	OD	OS			
YAG	OD	OS			

PATIENT NAME: \_\_\_\_\_

**PAST SURGERIES, INJURIES**

SURGERY / INJURY	WHEN	EXPLANATION

**SOCIAL HISTORY**

If you do not feel comfortable answering this portion of the form, please leave blank.

What is your marital status?				
Are you employed?		If yes, where?		
Do you drive?				
Do you have difficulty seeing to drive?		Seeing to drive at night?		
Do you wear glasses or contact lenses?				
Who is your medical doctor?		Where is your medical doctor located?		
Who is your optometrist?		Where is your optometrist located?		
Do you smoke? If yes, how much?				
Do you drink more than 2 servings of... (circle) Coffee Tea Soda Alcohol ?				
Have you ever had a transfusion?		If yes, where?		When?
If you have a guardian, please give name and phone number				

**FAMILY HISTORY**

EYE CONDITIONS	Right	Left	No	CONDITION	FAMILY HISTORY		
					YES	NO	FAMILY MEMBER
CATARACT(S)				BLINDNESS			
GLAUCOMA				GLAUCOMA			
BLURRED VISION				CATARACTS			
LOSS OF VISION				DIABETES			
PAINFUL (sore) EYE				CANCER			
DISTORTION, WAVINESS				HEART			
HALOS, STARBURSTS				STROKE			
LIGHT SENSITIVE/GLARE				BLOOD PRESSURE			
DOUBLE VISION				ARTHRITIS			
DISCHARGE FROM EYE(S)				(other)			
DRYNESS							
BUMPS AROUND EYE(S)							
CROSSED EYE(S)							

PLEASE WRITE ANY INFORMATION YOU WOULD LIKE DR JONES TO KNOW BELOW


# AUTHORIZATION FOR COMMUNICATIONS

PATIENT NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

## AUTHORIZED PERSON(S):

1. NAME: \_\_\_\_\_ RELATION: \_\_\_\_\_

PHONE: \_\_\_\_\_

2. NAME: \_\_\_\_\_ RELATION: \_\_\_\_\_

PHONE: \_\_\_\_\_

3. NAME: \_\_\_\_\_ RELATION: \_\_\_\_\_

PHONE: \_\_\_\_\_

I authorize release of the following information to the above named person(s):

### (CHECK ALL THAT APPLY BELOW)

1. Medical condition/ test results  yes  no
2. Billing or payment information  yes  no
3. Appointments (time and date)  yes  no

All information is considered private and confidential between Dr. Jones/staff and the patient unless otherwise authorized by the patient. This document serves as a release of information for the above named person(s). I understand I can revoke this at any time through written notice.

**PATIENT SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**SIGNATURE ON FILE**

PATIENT NAME: \_\_\_\_\_

MEDICARE POLICY #: \_\_\_\_\_

MEDIGAP INSURANCE NAME: \_\_\_\_\_

MEDIGAP POLICY #: \_\_\_\_\_

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Robert W. Jones, M.D. for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and it's agents any information needed to determine these benefits or the benefits payable for related services.

I request payment of authorized Medigap benefits be made to this provider and also authorize any holder of medical information about me to release to the above named Medigap insurer any information needed to determine benefits payable for services from this provider.

**PATIENT SIGNATURE:** \_\_\_\_\_

DATE: \_\_\_\_\_