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 consid-ered 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?
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			

LIST *ALL* MEDICATIONS	DOSAGE

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

EYE CONDITIONS	Right	Left	No
CATARACT(S)			
GLAUCOMA			
BLURRED VISION			
LOSS OF VISION			
PAINFUL (sore) EYE			
DISTORTION, WAVINESS			
HALOS, STARBURSTS			
LIGHT SENSITIVE/GLARE			
DOUBLE VISION			
DISCHARGE FROM EYE(S)			
DRYNESS			
BUMPS AROUND EYE(S)			
CROSSED EYE(S)			

FAMILY HISTORY

CONDITION	YES	NO	FAMILY MEMBER
BLINDNESS			
GLAUCOMA			
CATARACTS			
DIABETES			
CANCER			
HEART			
STROKE			
BLOOD PRESSURE			
ARTHRITIS			
(other)			

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: _____