PATIENT REGISTRATION

Date ______/______/______

Patient Name Last:__________________________ First: __________________________ Middle: _
[ ] **Male** [ ] **Female** [] **Mr** [ ] **Mrs** [ ] **Miss** [ ] **Master**

Address:________________________________ **City:** ________________ **State:** ________**Zip:** ____

Home Phone: (___)____________________ **Work:** (___)________________ **Cell:** (___)__________

Date of Birth: ______/______/______ **Age:** _______ **Social Security:** ______-______-________

Race: White __ Black__ Other _______ **Ethnicity:** Hispanic or Latino___ Not Hispanic or Latino___

Other__________ **Religion:** Catholic___ Jewish____ Other________

Preferred Method of Communication:____

Email Address: ____

Preferred Pharmacy:____

Responsible Party: (or guardian) Name:_______________________________________

Relationship to patient: __________________________ Phone Number: (____)______________________

Address: ____________________________ City: _________________ State: _______ Zip: ________

Employer Name: ______________________________ **Address:** ___________________________

Referred By: Who may we thank for your visit today? _______________________________________

Primary Care Physician:______________________________ **Phone number**_________________

Emergency Contact: Name: ________________________________ Phone #: (____)_____________

Relationship to Patient: ____

Does your plan require referrals for specialist care? [ ] Yes [ ] No

Primary Insurance:____

Policy # _______________________ Group# / Name _______________________ Copay $_______

Policyholder Name __________________________ Social Security # _______-_______-________

Birth Date _____/_____/_____ Patient relationship to policy holder: [ ] Self [ ] Spouse [ ] Child

Secondary Insurance:____

Policy # _______________________ Group# / Name _______________________ Copay $_______

Policyholder Name __________________________ Social Security # _______-_______-________

Birth Date _____/_____/_____ Patient relationship to policy holder: [ ] Self [ ] Spouse [ ] Child

Please turn page over for insurance payment disclosure & signature

Date: ____________________

Name: ____________________

EYE EXAMINATION QUESTIONNAIRE

Please tell us the reason of your visit today:

Eyelids | Eyelid lesions | Thyroid disease | Other: ______________

Lazy eyes | Turning eyes | Eye exam

How were you referred to us (please specify physician / school nurse / person / doctor)?

If so, who? ____________________

Please list any medications you are taking at this time, including eye drops: ____________________

____

Please list any known allergies to medications: ____________________

Please list any past surgeries: ____________________

Is there a chance you may be pregnant? ____________________

Please list any medical history: ____________________

Please list any eye history: ____________________

Please list any family history: ____________________

Social History

Alcohol use: ____________________

Smoking: ____________________

Recreational drug use: ____________________

Occupation: ____________________

With whom do you live? ____________________

Education: ____________________

(Please continue on reverse side)

Date: ____________________

Name: ____________________

PLEASE INDICATE YOUR: HEIGHT________ WEIGHT________

Circle any of the following areas which you may be interested in improving:

Drooping eyelids
Hollowing in lower eyelids
Lines between eyes (angry look)
Crease nose to corner of mouth
Lines around lips
Puffy eyelids
Excess eyelid skin

Thin face, hollow cheeks
Removal of moles, bumps or skin tags
Looking "tired"
Lines under and around eyes
Frown on the corner of mouth
Thin lips
Dark circles under eyes

Circle any of the following products/treatments you may be interested in:

Botox
Restylane
Juvederm
Perlane
Medical grade skin creams
Laser skin resurfacing
Browlift surgery
Eyelid surgery

HINDOLA KONRAD
M.D., F.A.C.S.

OPHTHALMIC FACIAL PLASTIC SURGERY
NEW YORK-PRESBYTERIAN HOSPITAL

To our valued patients,

The refraction is the part of the exam in which we check to see if you need a new eyeglass prescription. Medicare and some other insurance companies do not pay for this service. The fee for this service is $60.00.

Please check one of the following:

__ **I would like a Refraction today which I will pay for at the time of service.**

__ I do not want a Refraction.

_______________________________________ _______________

Patient's Name and Signature Date

315 CENTRAL PARK WEST
NEW YORK, NY 10025
212-758-0388

57 NORTH STREET, SUITE 415
DANBURY, CT 06810
203-794-0117

E-Prescribing Consent Form

E-Prescribing is defined as a physician's ability to electronically send an accurate and understandable prescription directly to the pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of care. E-Prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in the eprescribe program. These include:

- **Formulary and benefit transactions** – Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions** – Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- **Fill status notification** – Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that Dr. Hindola Konrad can request and use your prescription medication history from other health care providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Dr. Hindola Konrad to enroll me in the e-prescribe program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Print Patient Name____

Date____________________________ Patient DOB________________

Signature of Patient or Guardian________________________________

Relationship to Patient_____________________________________

Routine Eye Exam VS. Medical Exam

OUR OFFICE DOES NOT PARTICIPATE WITH ANY VISION PLANS.

If you have routine coverage it must be through your medical Insurance and not a separate vision plan

Routine Eye Exam:

- Eye exam done every year or every other year
- **NO Pre-existing condition.**
- General eye health check.
- No diagnostic testing would be done with this visit.
- **NO eye complaints of any nature.**

Medical Eye Exam:

- Eye exam done on a yearly basis
- Previous medical diagnosis including but not limited to: cataracts, glaucoma, diabetes, thyroid eye disease, plaquenil toxicity, etc.
- Any eye related complaints including but not limited to: eye discomfort, redness, tearing, etc.

I acknowledge I have read the above and fully understand the difference in the nature of the exams.

I understand that asking my physician to withhold a diagnosis would be committing insurance fraud.

I also understand that <u>ultimately</u>, it is the doctor's decision how my claim will be billed based on the <u>findings</u> of my exam <u>not</u> based on my insurance coverage.

Print Name____

Patient Signature________________________________ Date__________