Center for Sight
MIROYA MONSOUR, MD

PATIENT REGISTRATION

First name	**MI**	**Last name**

Date of birth	**Social security number**	**Email address**

Cell phone number	**Home phone number (or alternate)**

Text/email will be used for automated appointment reminders/confirmation as available.

Street address	**Apt**

City	**State**	**Zip**

PCP	**Pharmacy**
Primary insurance company	**Policy holder name and DOB (if not self)**
Marital status	**Spouse/significant other name/phone**
Gender (optional)	**Emergency contact name/phone**
Preferred language	**Race (optional)**
Employer/occupation	**Ethnicity (optional)**

Date:___________________________

Please fill out this whole sheet

Name:____________________ __ _____________DOB__________

Primary Doctor:___________ __ ______________________

Reason for Visit:__________ __ ______________________

Occupation:______________ __ _____________________

Smoking

Current Smoker ___

Previous Smoker ___

Never Smoked ___

Alcohol

Yes (How Many Per Week) ___

No ___

Eye Medications

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Medications

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Your Medical History

Diabetes ___

Thyroid ___

High Blood Pressure ___

Heart Attack ___

Blood Disorder ___

Stroke ___

Asthma ___

Arthritis ___

Heart Disease ___

Emphysema ___

Cancer (Form Of)___

C-Dif ___

Oxygen ___

Hepetitis C ___

MRSA___

Pacemaker___

Difibulator ___

C PAP ___

Surgical History (NOT EYE SURGERY)

____

____

____

____

Your Eye History

Cataract ___

Glaucoma ___

Retinal Detachment ___

Macular Degeneration ___

Lazy Eye ___

Eye Injury ___

Diabetic Eye Disease ___

Eye Surgery (Type of) ___

Review of Current Symtoms

Headache___

Migraine___

Dizziness___

Fainting___

Shortness of Breath___

Neurological___

Diabetics Last A1C and Glucose

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Allergies

____

____

____

____

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____

Would you like a copy of today's visit? Y___ N___

Family Health History

****F=Father M=Mother S=Sister B=Brother etc..

Medical

Diabetes ___

Cancer (Form of) ___

High Blood Pressure ___

Blood Disorder ___

Thyroid ___

Asthma ___

Heart Disease ___

Emphysema ___

Stroke ___

Eye

Cataract ___

Glaucoma ___

Retinal Detachment ___

Macular Degeneration ___

Lazy Eye ___

Diabetic Eye Disease ___

Center for Sight
MIROYA MONSOUR, MD

PATIENT ACKNOWLEDGMENTS

I understand that it is my responsibility to follow Dr. Monsour's advice for the care of my eyes. I also understand that although **Center for Sight-Miroya Monsour, MD** will send me a reminder, it is my responsibility to make follow–up appointments as instructed by the doctor or her assistant.

SIGNATURE____ DATE____________________

BILLING: I authorize **Center for Sight-Miroya Monsour, MD** to submit a claim to my insurance carrier or its intermediaries for all covered services rendered by the physician and authorize and direct my insurance carrier or its intermediaries to issue payment directly to Center for Sight-Miroya Monsour, MD. I authorize Center for Sight-Miroya Monsour, MD to furnish complete information to my insurance carrier and its intermediaries regarding services rendered.

SIGNATURE____ DATE_______________________

INSURANCE: **Center for Sight-Miroya Monsour, MD** does not accept VISION insurance plans.

I understand that MEDICAL insurance does not cover refraction for eyeglasses or contact lenses and that there is an out-of-pocket fee if I choose to have this service at the time of a MEDICAL exam.

I understand that there is an out-of-pocket fee for a VISION-ONLY exam that *includes* refraction for eyeglasses or contacts. I understand that it is my responsibility to submit any charges to my vision insurance company for reimbursement.

SIGNATURE____ DATE_______________________

HIPAA: I acknowledge that information regarding compliance with the Health Insurance Portability and Accountability Act has been made available to me and will be provided upon request.

SIGNATURE____ DATE_______________________

DILATION: Center for Sight-Miroya Monsour, MD uses eye drops that cause the pupil to become larger so that the retina can be seen clearly to help detect diseases of the eye. New patients are always dilated and returning patients are dilated as determined necessary by the doctor.

I understand that dilation may cause blurred vision (especially during reading) and light sensitivity for up to four hours.

SIGNATURE____ DATE_______________________

MEDICAL INFORMATION: (OPTIONAL) I authorize the following individuals to receive information about my diagnosis and treatment and to speak on my behalf regarding my care.

NAME____PHONE_____________________

NAME____PHONE_____________________

SIGNATURE____ DATE_______________________