Patient Registration and History **David L. Wirta, MD**

Date ________________ Whom may we thank for referring you? ________________________________

Patient Name ____

Address ____

____

city state zip

Phone No. (Home) ( ) ______________________ (Work/Cell) ( ) ______________ ( ) ______________

Sex ☐ Male ☐ Female Age _________ Birthdate ________________

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Patient SS# __________________________ Email ____

Occupation ____________________________________ *Spouse's Name* ______________________________

Employer ____________________________________ *Birthdate* ______________ *SS#* __________________

____________________________________ *Occupation* __________________________________

Spouse's Employer ____________________________

In case of Emergency, contact (specify someone who does not live in your household):

Name ________________________________ Relationship __________________________

Home Phone: ___________________________ Work Phone: ___________________________

Insurance information *(please present your insurance card to the receptionist)*

Who is responsible for this account? ____________________________________

Relationship to patient ________________________________

Insurance Co. ____

Group# ____________________________________

Is patient covered by additional insurance? Y / N

Subscriber name ____________________________________

Birthdate ________________ SS# _______________________

Relationship to patient __________________________________

Insurance Co. ____

Group# ________________________________

Assignment and Release:

I, the undersigned certify that I (or my dependent) have insurance coverage with _________________________________ and assign directly to Dr. Wirta all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____
Responsible Party Signature

____
Relationship Date

Medicare Authorization:

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Wirta for any services furnished me by that doctor. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits for the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Co-insurance and the deductible are based on the charge determination of the Medicare carrier.

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Signature of Beneficiary Date

Please turn over and complete information on other side

Patient Health History **David L. Wirta, MD**

Patient Name ______________________________ Date ______________

Please answer the following questions about your medical status and history:

1. Have you ever been treated for any **medical conditions** (e.g. diabetes, high blood pressure, arthritis, etc.)?

   Yes ☐ No ☐ If yes, please explain ______________________________

   ____

   Name of **Primary Care M.D.** ______________________________ Phone ______________

2. Have you ever had any **eye disease or surgery** (e.g. glaucoma, cataract, "lazy eye", retinal detachment, dry eye, etc.) ?

   Yes ☐ No ☐ If yes, please explain ______________________________

   ____

   Name of **Ophthalmologist or Optometrist** ______________ Date of last eye exam ______________

3. Have you ever had any **surgeries**?

   Yes ☐ No ☐ If yes, please explain ______________________________

   ____

5. Do you take any **medications**? Or **eye drops**?

   Yes ☐ No ☐ If yes, please list (with dose if known) ______________________________

   ____

   Name of Pharmacy ______________________________ Phone ______________

   Do you take aspirin, baby aspirin, ibuprofen, or herbal supplements? ______________

6. Do you have any drug or food **allergies**?

   Yes ☐ No ☐ If yes, please list: ______________________________

Review of Systems

Do you currently have any of the following problems:

	Yes	No	If yes, please explain:
Chronic fever,unexplained weight loss/gain,fatigue	☐	☐	
Ear/Nose/throat problems (e.g. hearing loss, sinus problems, sore throat)	☐	☐	
Heart problems (e.g. chest pain, irregular heart beat)	☐	☐	
Respiratory problems (e.g. shortness of breath, wheezing, coughing)	☐	☐	
Gastrointestinal problems (e.g. heartburn, abdominal pain, diarrhea, vomiting)	☐	☐	
Urinary problems (e.g. pain or discomfort, blood in urine)	☐	☐	
Skin problems (e.g. rashes, excessive dryness)	☐	☐	
Musculoskeletal problems (e.g. muscle aches, joint pain, swollen joints)	☐	☐	
Neurologic problems (e.g. numbness, weakness, headaches, paralysis)	☐	☐	
Psychiatric problems (e.g. depression, anxiety)	☐	☐	

7. Do any medical or eye diseases run in your **family** (e.g. diabetes, high blood pressure, cancer, glaucoma, macular degeneration)?

   Yes ☐ No ☐ If yes, please explain ______________________________

8. Do you smoke? Y / N If yes, how much? ☐ drink alcohol? Y / N If yes, how much? ☐

Comments: ______________________________

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______________________________ ______________

M.D. Signature Date