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.

_____

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	**Yes**	**No**	**If yes, please explain:**
Do you currently have any of the following problems:			
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: _____

_____

_____ _____

M.D. Signature Date