

~ PLEASE PRINT ~

PATIENT HISTORY QUESTIONNAIRE

NAME: \_\_\_\_\_

**PLEASE FILL OUT BOTH SIDES OF FORM COMPLETELY**

1. Why are you seeing the doctor today? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. How long has this condition existed? \_\_\_\_\_

3. Please check if you are experiencing any:

- |                          |                          |   |                          |                          |  |
|--------------------------|--------------------------|---|--------------------------|--------------------------|--|
| Yes                      | No                       |   | Yes                      | No                       |  |
| <input type="checkbox"/> | <input type="checkbox"/> | Eye Pain  | <input type="checkbox"/> | <input type="checkbox"/> | Light Flashes                                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Straight Lines Appear Crooked                           | <input type="checkbox"/> | <input type="checkbox"/> | Blurred Vision                                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Itchy/Watery Eyes                                       | <input type="checkbox"/> | <input type="checkbox"/> | Difficulty With Night Vision                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Headaches   | <input type="checkbox"/> | <input type="checkbox"/> | Sinus/Nasal Congestion                             |
| <input type="checkbox"/> | <input type="checkbox"/> | Problems Walking Due to Vision                          | <input type="checkbox"/> | <input type="checkbox"/> | Difficulty Working Due to Vision                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Problems Watching TV or Driving<br>with Current Glasses | <input type="checkbox"/> | <input type="checkbox"/> | Difficulty Reading/Writing<br>with Current Glasses |

Other: \_\_\_\_\_

4. Please list all medications you currently take & dosage (include eye & general medications)  
\_\_\_\_\_  
\_\_\_\_\_

5. Please list all ALLERGIES & reactions to medications (include eye & general medications)  
\_\_\_\_\_  
\_\_\_\_\_

6. Please list all previous surgery & dates (include eye & general surgeries)  
\_\_\_\_\_  
\_\_\_\_\_

**PLEASE TURN FORM OVER AND FILL OUT OTHER SIDE... THANKS**

7. Do you have a history of any of the following:

- |                          |                          |
|--------------------------|--------------------------|
| Yes                      | No                       |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |

- |                          |                          |
|--------------------------|--------------------------|
| Yes                      | No                       |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |

8. Do any of your relatives have:

- |                          |                          |
|--------------------------|--------------------------|
| Yes                      | No                       |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |

Relationship

---

---

---

---

---

---

---

---

9. Is there any family history of:

- |                          |                          |
|--------------------------|--------------------------|
| Yes                      | No                       |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |

---

---

---

---

---

---

---

---

10. Do you currently:

- |                          |                          |
|--------------------------|--------------------------|
| Yes                      | No                       |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |

11. Please list all doctors who should receive a report of your examination (include address if the doctor is not affiliated with Beaumont). If you have a Primary Care Physician, please indicate his/her name and address.

---

---

---

---

**THANK YOU FOR ANSWERING EVERY QUESTION ON THIS FORM!**

All the information given above is true to my knowledge,

Patient Signature

Date

Parent Signature (if minor)

Date

Physician Signature/Teaching Physician Signature

Date

**Consent to Share Person Health Information**

I give permission for the following people to have unlimited access to my medical records, appointment information, and billing information at **Orion Troy Ophthalmology**. I understand the following people will be able to make and cancel appointments for me, discuss billing questions any my medical information with the staff of **Orion Troy Ophthalmology**.

I also understand that at any time I can remove any of the names from this list in writing, and they will no longer have access to my information. This agreement is valid for a period of one year from the date of signature.

Name	Relationship	Phone Number

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
OTO Witness

\_\_\_\_\_  
Date

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

By signing below I acknowledge that I have received a copy of this office's Notice of Privacy Practices Form.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witnesses

\_\_\_\_\_  
Date

**Attestation of Patients Refusal to Sign**

Having been offered a copy of the Notice of Privacy Practices from Orion Troy Ophthalmology, the undersigned declares that the patient, \_\_\_\_\_  
declined to accept a copy or to sign the acknowledgement form.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

Registration Form

Charles G. Colombo, M.D.

Anuradha Y. Prasad, MD.

**DATE**

**NAME** \_\_\_\_\_ **Soc.Sec#** \_\_\_\_\_

**Last Name** \_\_\_\_\_ **First Name** \_\_\_\_\_ **Initial** \_\_\_\_\_

**Address** \_\_\_\_\_ **Home Phone** \_\_\_\_\_

**Cell #** \_\_\_\_\_ **or/Alternate Phone Number** \_\_\_\_\_

**City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Sex** /  **M**  **F** **Age** \_\_\_\_\_ **Birthdate** \_\_\_\_\_

**Single**  **Married**  **Widowed**  **Divorced** **SPOUSE NAME** \_\_\_\_\_

**Patient Employed by** \_\_\_\_\_ **Occupation** \_\_\_\_\_

**Business Address** \_\_\_\_\_ **Work Phone** \_\_\_\_\_

**Whom May we Thank for referring you to our office?** \_\_\_\_\_

**In case of emergency who should be notified?** \_\_\_\_\_ **Phone** \_\_\_\_\_

**E-MAIL ADDRESS**

**PHARMACY NAME & LOCATION**

**1) Primary Insurance Co. Name**

**Subscriber Name** \_\_\_\_\_ **Subscriber Date of Birth** \_\_\_\_\_

**Responsible Party** \_\_\_\_\_

**2)Secondary Insurance Company**

**THE RECEPTIONIST WILL NEED YOUR INSURANCE CARDS TO COPY FOR OUR RECORDS**

**ASSIGNMENT AND RELEASE OF INFORMATION**

I, THE UNDERSIGNED CERTIFY THAT I (OR MY DEPENDENT) HAVE INSURANCE COVERAGE & AUTHORIZE PAYMENT TO BE ISSUED TO CHARLES G. COLOMBO, M.D, DBA: ORION TROY OPHTHALMOLOGY ASSOCIATES, P.C..

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

Date

ORION TROY OPHTHALMOLOGY ASSOCIATES, P.C.

Charles G. Colombo, M.D.

**RESPONSIBLE PARTY**

All charges are due at the time of service unless we are participating with your insurance company, then we will file and expect payment within 45 days. You are responsible for any unmet deductibles, co-payments or noncovered services.

Are you personally responsible for the payment of your fees? Yes / No

If yes, will you be paying by: Cash / Check / Visa / Master Card / Discover

If no, who will be responsible?

Name \_\_\_\_\_ DOB \_\_\_\_\_

Relationship to you \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

**AUTHORIZATIONS**

**Authorization for treatment**

I hereby authorize and request medical treatment by the Orion Troy Ophthalmology Associates staff.

I further authorize the performance of whatever procedure the judgment of the above-named staff may deem necessary during any treatment. I also authorize the administration of any anesthetics and analgesics which above staff may deem advisable. (Note: eye drops and eye medications are considered anesthetics and analgesics.)

**Financial Agreement**

I acknowledge that payment is due at the time of treatment, unless other arrangements have been made. I accept full financial responsibility for all charges not covered by my insurance company. The above information is accurate and complete to the best of my knowledge.

**Assignment of Benefits**

All insurance forms processed by this office require assignment of benefits to this practice unless payment in full is made. Your cooperation in complying with terms of this assignment is appreciated. I, the undersigned, hereby authorize payment of medical surgical benefits directly to Orion Troy Ophthalmology Associates, P.C.

**Authorization to Release Information**

I hereby authorize my doctor / doctors to furnish the insurance company all information necessary to secure payment of benefits.

X \_\_\_\_\_  
Patient / Parent or Guardian Signature

\_\_\_\_\_  
Date

**MEDICARE PATIENTS**

**Medicare Lifetime Authorization**

I request the payment of authorized Medicare benefits be made on my behalf to Charles G.Colombo, M.D. for any services furnished to me by that physician/supplier/provider of care. I authorize any holder of medical information about me to release to Health Care Financing Administration (HCFA) and its agents any information needed to determine these benefits or the benefits payable to related services.

X \_\_\_\_\_  
Beneficiary's Signature

X \_\_\_\_\_  
Date