

REGISTRATION FORM (PLEASE PRINT)

Date _____ Home Phone (_____) _____ Cell Phone (_____) _____

PATIENT INFORMATION

Name _____ SS# _____
Last Name First Name Middle Initial

Address _____ Email _____

City _____ State _____ Zip Code _____

Sex Male Female Age _____ Birthdate _____ Married Separated Partnered for _____ yrs
 Minor Single Widowed

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer Phone (_____) _____

City _____ State _____ Zip Code _____

In case of Emergency who should be notified? _____

Phone (_____) _____ Relationship _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Middle Initial

Relation to Patient _____ Birthdate _____ SS# _____

Address (if different from Patient's) _____ Phone (_____) _____

City _____ State _____ Zip Code _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone (_____) _____

Insurance Company _____ Insurance Phone (_____) _____

Group # _____ Subscriber # _____ Copay _____

SECONDARY INSURANCE

Is patient covered by additional insurance? Yes No

Subscriber Name _____ Birthdate _____ Relation to Patient _____

Address (if different from Patient's) _____ Phone (_____) _____

City _____ State _____ Zip Code _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone (_____) _____

Insurance Company _____ Insurance Phone (_____) _____

Group # _____ Subscriber # _____ Copay _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent, have insurance coverage and assign directly to DuPage Ophthalmology, SC; Balaji Gupta, MD; Sheridan Lam, MD; and/or Sujaya Rupani, MD, 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 authorize the use of my signature on all insurance submissions. I authorize the use of my health care information and such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining services and determining insurance benefits or the benefits payable for related services. This consent will end upon termination of coverage with the above-named Insurance Company(ies) or one year from the date signed below.

Signature of Patient, Parent or Guardian or Personal Representative Date

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Pediatric New Patient Questionnaire

Patient Name: _____

Date: _____

Reason for visit: _____

Recent Symptoms:

- Crossed or wandering eye
- Excessive squinting
- Frequent tearing or discharge
- Frequent headaches

History of Eye Problems: None

- Glasses
- Patching
- Eye surgery
- Eye injury

Other eye problems: _____

Other Medical Problems: None

- Asthma/seasonal allergies
- Genetic disorder
- ADHD
- Heart problems
- Delayed development

Allergies to medications: None

List all medications: None

Family History of eye problems: None

- Amblyopia ("lazy eye")
- Strabismus ("crossed eye")
- Complications from anesthesia
- Genetic disease (runs in family)
- Glaucoma

Birth history (Infants only)

Birth weight: _____ lb, _____ oz

- Delivered more than 8 weeks early
- Problems during pregnancy (bleeding, diabetes, medications, alcohol)
- Forceps delivery
- Baby kept in hospital due to illness

Patient/Guardian Signature _____ Date _____

Doctor _____ Date _____