SHARP EYE CONSULTANTS, P.A.
DISEASES OF THE EYE AND VISUAL SYSTEM

Dr. Steven E. Campbell, OD

Dr. Julia R. Campbell, OD

Dr. Kirsti K. Ramirez, OD, FAAO

Patient Registration Form

Patient name: _____ Date of Birth: _____

Mailing Address: _____

City, State, Zip Code: _____ Sex: ____ Male ____ Female

Home Phone: _____ Cell Phone: _____

Marital Status: Married Single Widowed Divorced Social Security Number: _____

Emergency Contact: _____ Relationship: _____

Emergency contact phone number: _____

Do you authorize us to release medical information to this person? ☐ Yes ☐ No

Insurance Information:

Primary Insurance: _____ Policy #: _____
Policy holder: _____ Date of birth of policyholder if different from insured: _____
Social security of policy holder if different from insured: _____

Secondary Insurance: _____ Policy #: _____
Policy holder: _____ Date of birth of policyholder if different from insured: _____
Social security of policy holder if different from insured: _____

☐ Check if under the care of **HOSPICE**

Referred by: _____

Family Doctor: _____ ☐ Same as Referring Physician

Financial Responsibility

You will receive services today with the understanding that in the event your insurance coverage is not effective, you will be billed and held financially responsible for the services rendered.

Signature: _____ Date: _____

I authorize the release of any medical information necessary to process all claims.

Signature: _____ Date: _____

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Patient Medical Information

Date: _____

Name: _____ Date of Birth: _____ Sex: Female Male

PCP: _____ Pharmacy/Phone number: _____

PATIENT MEDICATION LIST (including over the counter)		

Eye History

Have you been diagnosed with any of the following?

Yes No Cataracts
Yes No Glaucoma
Yes No Retinal Tear or Detachment
Yes No Macular Degeneration
Yes No Iritis / Uveitis
Yes No Eye Injury

Cataract Surgery (Date of Surgery)

Right: _____ Left: _____

Other Eye Surgeries (Date):

_____

_____

Please list any ocular medications below:

_____

Family Eye History

Yes No Glaucoma
Yes No Macular Degeneration
Yes No Crossed Eyes/Strabismus
Yes No Blindness
Yes No Retinal detachment

Medical History

Have you been diagnosed with any of the following?

Yes No Diabetes _____ # of years?
Yes No High Blood Pressure
Yes No Heart Disease
Yes No High Cholesterol
Yes No Stroke or TIA
Yes No COPD
Yes No Asthma
Yes No Rheumatoid Arthritis
Yes No Lupus
Yes No Sarcoidosis
Yes No Cancer (Type: _____)
Yes No Thyroid (Hyper/Hypo)

Do you have any medication allergies?

☐ Yes ☐ NKDA

If yes, please list: _____

_____

_____

Social History

Yes No Drink Alcohol?
Yes No Smoke Tobacco?

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Acknowledgement of Review of Notice of Privacy Practices

I have reviewed and understand SHARP EYE CONSULTANTS Notice of Privacy Practices, which explains how my medical information will be used and disclosed and how I can get access to my medical information. I know that I may have a copy of the Notice. I also know that from time to time, SHARP EYE CONSULTANTS may revise the Notice of Privacy Practices. If I want the revised Notice of Privacy Practice, I know I must ask for it.

X _____

Signature of Patient or Personal Representative

_____

Date

_____

Name of Patient or Authorized personal Representative

I authorize the following individuals to have access to my medical information and/or record:

_____ _____

Name/Relationship Name/Relationship