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New Patient Registration Form

DVRA_NP_F100 *New Pt Packet V11.09.23*

Patient Information

Patient Last Name	First Name		Middle Name	Maiden Name	
Address (Street or Box)			City	State	Zip Code
Home Phone Number	Cell Phone Number		Work Phone Number	E-Mail	
Social Security Number	Date of Birth	Assigned Sex at Birth ☐Male ☐ Female	Pronouns ☐She/Her/Hers ☐He/Him/His ☐They/Them/Theirs ☐Other: Please specify: _____		
Gender Identity (Check One) ☐ Identify as Male ☐ Identify as Female ☐ Gender Nonconforming/Non-binary ☐ Other (Please specify)_____ ☐ Choose not to disclose			Sexual Orientation (Check One) ☐ Lesbian/Gay/Homosexual ☐Straight/Heterosexual ☐ Bisexual ☐Something else, please describe _____ ☐ Don't Know ☐ Choose not to disclose		
Marital Status (Check One) ☐Single ☐Married ☐Domestic Partner ☐Separated ☐Divorced ☐Widowed ☐Unknown			Race (Check One) ☐ American Indian or Alaska Native ☐Hispanic or Latino ☐ Native Hawaiian or other Pacific Islander ☐ Black or African American ☐ Asian ☐ White ☐Other _____		
Ethnicity (Check One) ☐ Not Hispanic or Latino ☐ Hispanic or Latino			Employer Name	Employer Address	
Is patient residing in a Skilled Nursing Facility/ Rehabilitation Center? **☐ Yes ☐ No**			**If Yes, Name of Facility**	**City:** **Phone Number:**	
Primary Care Physician Name			Phone Number		
Emergency Contact & Relationship	Phone Number		Referring Physician Name	Phone Number	

Responsible Party

Complete this section ONLY if Patient is a minor or has a Legal Guardian				
Responsible Party Last Name	First Name	Middle Name	E-Mail:	
Address (Street or PO Box)		City	State	Zip Code
Home Phone Number		Cell Phone Number	Work Phone Number	
Relationship to Patient ☐Self ☐Other (specify)		Date of Birth	Social Security Number	

Insurance and Subscriber Information

PRIMARY Insurance Company		Effective Date	**SECONDARY** Insurance Company		Effective Date
Claims Mailing Address (Street or PO Box)			Claims Mailing Address (Street or PO Box)		
City	State	Zip Code	City	State	Zip Code
Policy ID Number	Group ID Number		Policy ID Number	Group ID Number	
Subscriber Name (Policy Holder)	Date of Birth		Subscriber Name (Policy Holder)	Date of Birth	
Subscriber Social Security Number	Relationship to Patient		Subscriber Social Security Number	Relationship to Patient	
Subscriber Employer	Work Phone Number		Subscriber Employer	Work Phone Number	
Subscriber Employer Address (Street or PO Box)			Subscriber Employer Address (Street or PO Box)		
City	State	Zip Code	City	State	Zip Code

Pharmacy

Preferred Pharmacy Name	Pharmacy Address	Pharmacy Phone Number
Mail-Order Pharmacy Name	Pharmacy Address	Pharmacy Phone Number

Vision Insurance (if applicable)

Vision Insurance and Subscriber Information

VISION Insurance Company		Effective Date
Claims Mailing Address (Street or PO Box)		
City	State	Zip Code
Policy ID Number	Group ID Number	
Subscriber Name (Policy Holder)	Date of Birth	
Subscriber Social Security Number	Relationship to Patient	
Subscriber Employer	Work Phone Number	
Subscriber Employer Address (Street or PO Box)		
City	State	Zip Code

_____ _____

Signature of Patient, Parent, or Legal Guardian **Date**

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Consent to Treat and Financial Responsibility

Consent to Treat *DVRA_NP_F101*

I hereby authorize employees and agents of Associated Retinal Consultants, LLC ("ARC") dba Delaware Valley Retina Associates, an Affiliate of PRISM Vision Group, including physicians, physician assistants, nurse practitioners and other employees and staff members to render medical evaluations and care to the patient indicated below. The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in the case of an emergency.

_____

Patient Name (Please PRINT)

_____ _____

Signature of Patient, Parent, or Legal Guardian **Date**

Complete this section ONLY if patient is a minor or requires a Legal Guardian

I consent for _____ to authorize evaluation and treatment for the patient identified above when I am not available. I understand that this authorizes the foregoing person(s) to consent to medical and surgical procedures and immunizations for the patient. The duration of this consent is indefinite and continues until revoked in writing.

_____ _____

Signature of Patient, Parent, or Legal Guardian **Date**

Financial Responsibility *DVRA_NP_F102*

I hereby authorize Associated Retinal Consultants, LLC ("ARC") dba Delaware Valley Retina Associates, an Affiliate of PRISM Vision Group, to apply for benefits on my behalf and for payment of medical benefits directly to ARC for services rendered. I request payments of Medicare, Medigap and/or any other insurance company to be made directly to ARC. Authorization is hereby granted to release information contained in the patients' medical record or the patient's medical insurance company (or its employees or agents) as may be necessary to process and complete the patient's medical claim. I understand that I am financially responsible for all charges for services rendered which may include services not covered by the patient's insurance companies. I agree that all amounts are due upon request and are payable to ARC.

The duration of this authorization is indefinite and continues until revoked in writing. I understand that by not signing this release of information, I am responsible for payment of services in full before services are rendered.

_____

Patient Name (Please PRINT)

_____ _____

Signature of Patient, Parent, or Legal Guardian **Date**

Preferred Method of Communication *DVRA_NP_F104*

☐ **Yes**, I want Associated Retinal Consultants, LLC ("ARC") dba Delaware Valley Retina Associates, an Affiliate of PRISM Vision Group, to communicate my information with me through a secure system that is designed to keep my information safe.

My preferred method of communication regarding my **medical conditions and/or appointment information** is indicated below:

☐ Home Phone ☐ Cell Phone ☐ Email ☐ Mailed Letter ☐ Guardian

If the above method of communication is by **phone**, please do one of the following (**please check ONE**):

☐ Leave a message with detailed information.
☐ Leave a message with a call-back number only.

If the above method of communication is by **email**, please consider the privacy implications; for example, any other person that may have access to your e-mail address or any other person, such as your employer, that may have the right and/or ability to review all e-mail received at your work address.

Please let our office know if you have any special directions or requests regarding our communication with you. For example, please let us know if you would like us to call you at a different phone number for a specific test result or if you do not want to be contacted at all.

Approved HIPAA Contacts *DVRA_NP_F105*

Keeping our patient's information private is important to us, and by default we will disclose information related to the patient's Billing Account and Medical Conditions only to the patient or legal guardian.

If you would like to add additional contacts, other than the patient or legal guardian, that Associated Retinal Consultants, LLC ("ARC") dba Delaware Valley Retina Associates, an Affiliate of PRISM Vision Group, is allowed to disclose this type of information to, please complete the fields below and select the appropriate checkboxes based on your approval for each person you listed. If the End Date is left blank, then the duration of this authorization is indefinite unless otherwise revoked in writing.

_____	_____	_____	_____
Contact Name	Relationship to Patient	Contact Phone Number	End Date

☐ **Billing Account Information** ☐ **Medical Condition Information** ☐ **Emergency Contact**

Additional Notes: _____

_____	_____	_____	_____
Contact Name	Relationship to Patient	Contact Phone Number	End Date

☐ **Billing Account Information** ☐ **Medical Condition Information** ☐ **Emergency Contact**

Additional Notes: _____

Patient Name: _____ **Date:** ____/____/____

The Notice of Privacy Practices describes how Protected Health Information about you may be used and disclosed and how you can get access to this information. Please review carefully.

Associated Retinal Consultants, LLC ("ARC") dba Delaware Valley Retina Associates, an Affiliate of PRISM Vision Group, is required by law to protect the privacy of health information that may reveal your identity, and to provide you with a copy of this notice, which describes the health information privacy practices of our practice, its medical staff, and affiliated health care providers that jointly perform payment activities and business operations with our Practice. "Protected Health Information" is information about you, including demographic information, that may identify you as well as genetic information, and information that relates to your past, present or future physical or mental health or condition and related health care services.

On ____/____/____ I, _____, received a copy of this office's Notice of Privacy Practices.
(Today's Date) (Patient's Name)

_____
Please Print Name

_____
Signature

_____
Date

* Delaware Valley Retina Associates' Notice of Privacy Practices can also be found on our website: https://www.dvra.net/

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

This Acknowledgement Form will become part of your permanent medical record.

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Medical Questionnaire / Eye History

DVRA NP F108

Patient's Name:				Date / /
What ocular problem brings you in?				
When was your last eye exam?	/ /	Eye Doctor		
What did your doctor tell you?				

	YES	NO			
Do you wear glasses for vision?					
Do you wear contact lenses?			If so, last time they were changed?		
Do you have Glaucoma?			If so, how is it being treated?		
Have you had cataract surgery?			If so, Which Eye?	Date of Surgery	Name of Surgeon
			Left Eye	/ /	
			Right Eye	/ /	

Have you had other surgery? *Please list details below*

Medical History – Social History

Have you ever suffered from any of the following?

	YES	NO	Comment
Born Prematurely?			
History of Weight Loss, Fever?			
Headaches, Sinus, Tonsillectomy?			
Heart Condition?			
High Blood Pressure?			
Circulatory Problems?			
Lung Disease?			
Ulcers, Liver, Gall Bladder Disease?			
Do you Smoke?			
Do you Drink?			
Kidney, Bladder, Prostate Disease?			

	YES	NO	Comment
Joint Disease?			
Skin Disease or Breast Cancer?			
Stroke or Neurological Disease?			
History of Psychological Disease?			
Thyroid Disease?			
Diabetes?			
Date of Last Blood Sugar Results:			
Bleeding Disorder, Anemia?			
Aids or Infectious Disease?			
Cancer?			

List ALL Medications that you are presently taking, including any eye drops:	List ALL Allergies Including Medications:

FAMILY HISTORY

Is there a family history of	YES	NO		
Cataracts?			Relative:	
Glaucoma?			Relative:	
Retinal Disease?			Relative:	
Diabetes?			Relative:	
Hypertension?			Relative:	
Anemia?			Relative:	
Other Eye or Systemic Disease?			Relative:	

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Medical History Questionnaire / Review of Symptoms

DVRA_NP_F109

Patient's Name:	Date / /

Do you have any problems in the following areas? *Please check all applicable*

	YES	NO			YES	NO	
GENERAL				**GI / GU**			
Fever				Vomiting			
Fatigue				Bloody Bowel Movement			
Weight Loss / Gain				Heartburn			
Frequent Colds				Loss of Appetite			
EYES				Difficulty with Urination			
Blurred Vison				Blood in Urine			
Double Vision				Frequent Urination			
Redness				Pain in Urination			
Sandy or Gritty Feeling				**MUSCULOSKELETAL**			
Blind Spots				Muscle Pain			
Floaters				Joint Pain, Arthritis			
Flashes				**INTEGUMENTARY**			
Lazy Eye				Rash, Bruise Easily			
Itching / Burning				Breast Disease			
Excess Tearing				**NEUROLOGICAL**			
Glare / Light Sensitivity				Fainting, Frequent Headaches			
Eye Pain				Seizures			
Chronic Infection Eye / Lid				**PSYCHIATRIC**			
ENT: Ears, Nose & Throat				Depression			
Sinus Infection				Anxiety			
Cough				Psychiatric Problems			
Trouble Walking				**ENDOCRINE**			
Hoarseness				Excessive Thirst			
Loss of Hearing				Excessive Sweating			
Nose Bleeds				**HEMATOLOGIC / LYMPHATIC**			
HEART				Swollen Glands			
Chest Pain				**ALLERGIC / IMMUNOLOGIC**			
Irregular Heart Beat				Seasonal Allergies			
Pacemaker				Hay Fever			
Heart Murmur				**OTHER**			
Swollen Feet / Ankles				Pregnant			
Leg Cramps when Walking				Menopausal			
LUNGS				Vaginal Bleeding			
Wheezing, Shortness of Breath				Breast Lumps			
Coughing up Blood / Phlegm							

COMMENTS REGARDING ABOVE ANSWERS: (PLEASE PRINT)