



BABAK SHABATIAN, M.D.
RULON D. BEESLEY, M.D., P.C

Diplomates of the American Board of Ophthalmology

PATIENT REGISTRATION FORM FORMULARIO DE INSCRIPCION DEL PACIENTE

Please PRINT. All information must be completed. If not applicable, please mark N/A. *Por favor, IMPRIMA: Toda la información debe ser completado. Si no es aplicable, por favor marque N/A.*

Name: Last, First, MI _____
Nombre: Apellido, nombre, inicial

Today's Date: _____
Fecha de hoy

If minor, Responsible Parent Name: _____
Si el paciente es menor, padre responsable

Date of Birth: _____
Fecha de Nacimiento:

Marital Status: Married/Divorced/Single/Widowed/Separated: _____
Estado civil: Casando/Divorciado/Soltera/viudos/separados

SSN#: _____
Número de Seguro Social

Home Address: _____ City: _____
Dirección de casa Ciudad

State: _____ Zip: _____
Estado Código Postal

Home Telephone: _____ Cell phone: _____ Work Phone: _____
Teléfono de Casa Teléfono celular Teléfono de Trabajo

Email: _____

Do You...
Prefer we call your home or cell number? HOME/CELL _____
¿Prefiere que le llame a su casa o celular? Casa/Celular
Want to receive EMAIL reminders about upcoming appts? YES/NO _____
¿Le gustaria recibir recordatorios por correo electrónico sobre Citas próximas? SI/NO

Employer: _____
Empleador

Occupation: _____
Ocupación

Primary Care Physician Name: _____
Nombre de Médico de Atención Primaria

PCP Phone #: _____
Teléfono del PCP

Referring Physician Name (if different from above): _____
Nombre de referencia del médico (si es diferente del anterior)

Ref Phys #: _____
Teléfono de referencia del médico

Emergency Contact: _____ Relationship: _____ Phone#: _____
Contacto de Emergencia Relación Teléfono

MEDICAL INSURANCE INFORMATION INFORMACION DEL SEGURO MEDICO

Primary Insurance: _____
Seguro Primario

Insured Party's Name: _____
Nombre del Asegurado

Insured's DOB: _____
Fecha de nacimiento del asegurado

Relationship to Insured: Self/Spouse/Child/Other _____
Relación con el Asegurado: Cónyuge/Hijo/

Insured's SSN #: _____
Otro Asegurado SSN

Secondary Insurance: _____
Seguro Secundario

Insured Party's Name: _____
Nombre del Asegurado

Insured's DOB: _____
Fecha de nacimiento del asegurado

Relationship to Insured: Self/Spouse/Child/Other _____
Relación con el Asegurado: Cónyuge/Hijo/

Insured's SSN#: _____
Otro Asegurado SSN

ROUTINE/VISION INSURANCE INFORMATION RUTINA/INFORMACION VISION DE SEGUROS

Vision Insurance: _____
Seguro de Visión

Insured Party's Name: _____
Nombre del Asegurado

Insured's DOB: _____
Fecha de nacimiento del asegurado

Relationship to Insured: Self/Spouse/Child/Other _____
Relación con el Asegurado: Cónyuge/Hijo/Otros

Last 4 of SSN#: _____
Pasado 4 de SSN:

***PLEASE NOTE! Medical Examinations/Treatment are not covered by ROUTINE Vision Plan Insurance.
***POR FAVOR NOTA! Exámenes médicos y tratamiento no están cubiertos por el Seguro RUTINA Plan para la Visión.

I acknowledge that the information provided is complete and accurate. *Reconozco que la información proporcionada es complete exact.*

Patient/Designated Representative Signature *Paciente/Representante Designado*

Date *Firma Fecha*



We are glad that you have chosen Babak. Shabatian, MD, INC as your eye care provider. Please read the important notifications below, so that you may become familiar with our practice policies.

Refraction

Refraction (testing for best corrected Visual Acuity, glasses and/or contact lens prescriptions) is not covered by Medical insurance. In the absence of qualifying Vision coverage, Refraction fees are the responsibility of the patient. Current Refraction fees are as follows: Best Correct Visual Acuity and Glasses Refraction - \$45, Contact Lens Refraction - \$85. New Contact Lens fitting fees start at \$150.

Dilation

Please note that your eyes may be dilated during your examination. Dilation of your pupils may blur your vision and make you sensitive to light for several hours after your examination. It is important to refrain from driving and performing precision work with tools when your vision is blurred from dilation. It is not possible to predict how long the effect of dilation will last or how much your vision will be affected. We recommend that you wear sunglasses when your eyes are dilated, please ask the check out staff for a complimentary disposable pair if you do not have yours with you.

Pharmacy Prescriptions

You may be given a prescription for medication or medication refills in conjunction with your care. It is important that you check with your pharmacist and/or primary care physician regarding potential interactions with other medications you are currently taking. Our doctors recommend that you check with www.prescribingreference.com to become aware of all potential risks, benefits and interactions for all medications.

HIPPA Privacy Practices

Babak Shabatian, MD, INC. follows HIPPA guidelines in regard to your PHI (Protected Health Information). Copies of our Notice of Privacy Practices are available at the front desk. By signing below, you acknowledge that you have read and agreed to our Privacy Practices.

Administrative Fees

There is a minimal clerical charge of \$25 for any administrative forms the office completes. This includes vision forms, DMV vision forms, jury service, or supplemental insurance forms. There is minimal clerical charge of \$15 for medical records that are copied in the office and/or sent to another party. Legal office seeking such records will incur additional fees.

Insurance Assignment and Release

I certify that I have insurance coverage with the company(ies) I provided and assign directly to Babak Shabatian, MD, INC, 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 they are paid by insurance. I authorize the use of signature on all insurance submissions. The above medical group may use my health care information and may disclose such information to the above-mentioned insurance company(ies) and their agents for the purpose of coordinating care, obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Medicare/Medigap Authorization

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made to Babak Shabatian, MD, INC for any services furnished to me. To the extent permitted by law, I authorize any hold of medical or other information about me to release to the Centers of Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

Vision Plan (Routine) Insurance

I acknowledge that Vision Plan (Routine) Insurance covers routine eye examinations, refractions, contact lens refractions, and may cover materials (contact lenses, glasses) as specified by my plan benefits. I understand that Medical Examinations and Treatment are NOT covered under my vision (routine) insurance. I understand that services related to medical conditions will be billed to my Medical insurance or, if no applicable medical coverage exists, these services are my responsibility at the time of service.

CoPays, Deductibles, and Non Covered Services

I acknowledge that I am financially responsible for copays, deductibles and non-covered services; and that those amounts will be collected at the time of service. Should my insurance plan apply any portion of the services rendered by the providers at Babak Shabatian, MD, INC to my deductible, coinsurance, copay or otherwise deem the costs my responsibility, I agree to pay the outstanding amount owed, promptly (within 30 days from the date that I receive the EOB (Explanation of Benefits)) from my insurer, and acknowledge that the amount is owed by me whether or not I receive an invoice from Babak Shabatian, MD, INC.

Billing and Collections

I acknowledge that Babak Shabatian, MD, INC is providing services in good faith that will be appropriately compensated in a timely manner. If necessary, the patient and/or guarantor will be held liable for any late fees, interests, collection fees, and/or reasonable attorneys' fees for the prosecution and/or collection of the patient amount owed. It is the patient's and/or guarantor's responsibility to provide Babak Shabatian MD, INC with updated billing and insurance information on each and every visit.

Patient/Designated Representative Signature

Date

Patient Medical History

Patient Name _____

Date _____

Tell us about your eye health

Last Eye Exam Date: _____

Where/ Which Doctor: _____

Do You Wear: None Glasses Readers Only Contact Lenses Glasses And Contact Lenses

Please Mark Any Condition You Have Presently Or Have Had In The Past:

- Dry Eyes
- Glaucoma
- Cataracts
- Macular Degeneration
- Retinal Detachment
- Keratoconus
- Other: _____

Please Mark Any Condition Your Family Member Have Presently Or Have Had In The Past:

- | | |
|---|--------------|
| | Relationship |
| <input type="checkbox"/> Cataracts | _____ |
| <input type="checkbox"/> Dry Eyes | _____ |
| <input type="checkbox"/> Glaucoma | _____ |
| <input type="checkbox"/> Keratoconus | _____ |
| <input type="checkbox"/> Macular Degeneration | _____ |
| <input type="checkbox"/> Retinal Detachment | _____ |
| <input type="checkbox"/> Other: | _____ |

Have You Had any Eye Surgeries? No Surgeries

What	Date	Physician	Comments
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please List any EYE Medications you currently use No Eye Medications

Name	Dosage	Right/Left Eye	Begin Date	End Date
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Tell us about your general medical health

Primary Care Provider: _____

Last Visit to PCP Date: _____

Medical Conditions

Please Mark Any Condition You Have Presently Or Have Had In The Past:

Please Mark Any Condition Your Family (Blood Relative) Have Presently Or Have Had In The Past

- | | | |
|---|----|------------------------------|
| Yes | No | No Known Medical Conditions |
| Yes | No | High Blood Pressure |
| Yes | No | Heart Problem |
| Yes | No | Arthritis → Rheumatoid/Osteo |
| Yes | No | Lung Problems |
| Yes | No | Stroke |
| Yes | No | Thyroid Problems |
| Yes | No | Diabetes → Type 1 OR Type 2 |
| <input type="checkbox"/> Diet <input type="checkbox"/> taking Insulin <input type="checkbox"/> no insulin | | |

- | | | | |
|-----|----|------------------------------------|----------------|
| Yes | No | No Known Family Medical Conditions | |
| Yes | No | High Blood Pressure | RELATION _____ |
| Yes | No | Heart Problem | _____ |
| Yes | No | Arthritis - Rheumatoid/Osteo | _____ |
| Yes | No | Lung Problems | _____ |
| Yes | No | Stroke | _____ |
| Yes | No | Thyroid Problems | _____ |
| Yes | No | Diabetes | _____ |
| Yes | No | LDL | _____ |

Medical Conditions

Please Mark Any Condition You Have Presently Or Have Had In The Past:

Yes No High Cholesterol
Yes No Ulcers
Yes No Cancer
Yes No Migraine/Headache
Yes No Sleep Apnea
Yes No Others: _____

Please Mark Any Condition Your Family (Blood Relative) Have Presently Or Have Had In The Past

RELATION
Yes No Ulcers _____
Yes No Cancer _____
Yes No Sleep Apnea _____
Yes No Other: _____

Vaccinations :

Received a Flu Vaccine? No Yes When? _____

Received Pneumonia Vaccine? No Yes When? _____

Have You Had any Surgeries *other than eye surgery*?

What	Date	Physician	Comments
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Social History

Smoke? No Yes If Yes, Years Frequency? Pack Per Day Type? Cigarette Cigar Tobacco

Alcohol Use? Never If Yes, Beer Spirits Wine Frequency? Per Day Per Week Occasionally

Recreational Drugs: _____ Frequency? _____

Medications No Medications

Name	Dosage	Instruction	Begin Date	End Date
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Allergies No Known Allergies

Name	Begin Date	Reactions/Comments
_____	_____	_____
_____	_____	_____

Pharmacy information:

Name: _____ Address: _____ Phone: _____

