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 applicable, por favor marque N/A.*

Name: Last, First, MI_____ Today's Date:_____
Nombre: Apellido, nombre, inicial *Fecha de hoy*

If minor, Responsible Parent Name:_____ Date of Birth:_____
Si el paciente es menor, padre responsable *Fecha de Nacimiento:*

Marital Status: Married/Divorced/Single/Widowed/Separated:_____ SSN#:_____
Estado civil: Casando/Divorciado/Soltera/viudos/separados *Número de Seguro Social*

Home Address:_____ City:_____ State:_____ Zip:_____
Dirección de casa *Ciudad* *Estado* *Código Postal*

Home Telephone:_____ Cell phone:_____ Work Phone:_____ Email:_____
Teléfono de Cosa *Teléfono cellular* *Teléfono de Trabajo*

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

Employer:_____ Occupation:_____
Empleador *Ocupación*

Primary Care Physician Name:_____ PCP Phone #:_____
Nombre de Médico de Atención Primaria *Teléfono del PCP*

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

Emergency Contanct:_____ Relationship:_____ Phone#:_____
Contacto de Emergencia *Relación* *Teléfono*

MEDICAL INSURANCE INFORMATION *INFORMACION DEL SEGURO MEDICO*

Primary Insurance:_____
Seguro Primario

Insured Party's Name:_____ Insured's DOB:_____
Nombre del Asegurado *Fecha de nacimiento del asegurado*

Relationship to Insured: Self/Spouse/Child/Other _____ Insured's SSN #:_____
Relación con el Asegurado:/Cónyuge/Hijo/_____ *Otro Asegurado SSN*

Secondary Insurance:_____
Segura Secundario

Insured Party's Name:_____ Insured's DOB:_____
Nombre del Asegurado *Fecha de nacimiento del asegurado*

Relationship to Insured: Self/Spouse/Child/Other_____ Insured's SSN#:_____
Relación con el Asegurado:/Cónyuge/Hijo/_____ *Otro Asegurado SSN*

ROUTINE/VISION INSURANCE INFORMATION *RUTINA/INFORMACION VISION DE SEGUROS*

Vision Insurance:_____
Seguro de Visión

Insured Party's Name:_____ Insured's DOB:_____
Nombre del Asegurado *Fecha de nacimiento del asegurado*

Relationship to Insured: Self/Spouse/Child/Other_____ Last 4 of SSN#:_____
Relacion con el Asegurado: Cónyuge/Hijo/Otros *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*

Ve are glad that you have chosen Babak. Shabatian, MD, INC as your eye care provider. Please read the important notifications below, s 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 qualifyin Vision coverage, Refraction fees are the responsibility of the patient. Current Refraction frees are as follows: Best Correct Visual Acuity and Glasses Refractio -$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 your 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 singing 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
_Cataracts	_____
_Dry Eyes	_____
_Glaucoma	_____
_Keratoconus	_____
_Macular Degeneration	_____
_Retinal Detachment	_____
_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:

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
		☐Diet ☐taking Insulin ☐no insulin

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

Yes	No	No Known Family Medical Conditions	
			RELATION
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	_____
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 :

Recevied 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:_____