RAYMOND T. PEKALA, M.D.

PATIENT REGISTRATION

Last Name: _____ Date: _____

First Name: _____ MI: ____

Address: _____

City/State: _____ Zip Code: _____

SEX: M F

Marital Status:
Single Married Divorced Widowed Separated

Social Security Number: _____

Date of Birth: _____

Phone Numbers
Home: _____
Work: _____
Cell: _____

E mail: _____

Parent/Guardian/Emergency Contact:
Name: _____
Relationship: _____
Phone: _____

Primary Care Doctor
Name: _____
Address: _____
_____zip____
Phone: _____

INSURANCE INFORMATION

Primary Insurance: _____
ID Number: (Please Include Letters and Numbers) _____
Group Number: _____ Effective Date of Coverage: _____
Subscriber Information (If Other Than Yourself)
Name: _____ Date of Birth: _____ Relationship: _____

Secondary Insurance: _____
ID Number: (Please Include Letters and Numbers) _____
Group Number: _____ Effective Date of Coverage: _____
Subscriber Information (If Other Than Yourself)
Name: _____ Date of Birth: _____ Relationship: _____

Insurance Authorization: I herby assign all medical and/or surgical benefits to which I am entitled, including Medicare and any private health plan to: Raymond T. Pekala, M.D. I understand that I am financially responsible for any amount not covered by insurance or any amount deemed the subscriber's responsibility as defined by my insurance company, particularly co-payments and deductibles.

Signature: _____ Date: _____

NAME: _____DATE:_____

WHO REFERRED YOU HERE TODAY? _____

EYE PROBLEMS (PRESENT AND PAST): _____

MEDICAL PROBLEMS: _____
_____

MEDICINES: _____
_____

EYE DROPS (PLEASE INDICATE WHICH EYE, HOW OFTEN): _____
_____

ALLERGIES (INCLUDING DRUG ALLERGIES):
_____

SOCIAL HISTORY:

OCCUPATION: _____

DO YOU SMOKE? (Circle your smoking status)

Current every day smoker	Heavy Tobacco smoker
Current some day smoker	Light Tobacco smoker
Former smoker	Smoker, current status unknown
Never smoked	Secondhand Smoke

DO YOU DRINK ALCOHOL? Y___N___ HOW MUCH? _____

FAMILY HISTORY:

Y	N	DIABETES	Y	N	RETINAL DETACHMENT
Y	N	GLAUCOMA	Y	N	OTHER _____
Y	N	MACULAR DEGENERATION			

PREFERRED LANGUAGE:

RACE (circle one)

Other	Pacific Islander
American Indian or Alaska Native	White
Black or African-American	Unavailable
Asian	Declined/Unable to determine

ETHNICITY (circle one)

Other	Declined/Unable to determine
Hispanic/Latino	Non-Hispanic/Latino
Arab-American	Unavailable

NAME: _____ DATE: _____

REVIEW OF SYSTEMS – LIST ANY PROBLEMS IN ANY OF THE FOLLOWING AREAS (CIRCLE NO IF YOU HAVE NOT HAD ANY PROBLEM)

Y N GENERAL _____
Y N STOMACH &INTESTINE _____
Y N EAR, NOSE & THROAT _____
Y N KIDNEY, BLADDER, PROSTATE _____
Y N HEART _____
Y N BONES & JOINTS _____
Y N THYROID _____
Y N SKIN _____
Y N LUNGS _____
Y N NERVOUS SYSTEM _____
Y N MENTAL ILLNESS _____
Y N BLOOD _____

PHARMACY YOU WOULD LIKE TO USE

_____
_____
_____