Please complete all patient information forms attached. To better assist you in a timely manner, to guarantee communication with your referring and primary care physicians and to properly care for you, it is very important that we receive all of the enclosed information upon your arrival at Galiani Ophthalmology Associates. In order to ensure efficiency in billing functions and precert procedures, it is pertinent that all insurance information be accurate and current. Thank you for completing all of the forms enclosed.

Information Regarding Your Office Visit:

- Your visit with us may last 30 minutes to 90 minutes depending on the type of evaluation you require.
- Your eyes may be dilated for the examination, please bring sunglasses if you have them, if not please ask our receptionist for a pair. You may also need a driver if you feel you are unable to drive with dilated pupils due to light sensitivity, glare or blurred vision.

On the Day Of Your Appointment You Will Need To Bring The Following:

- ____ The completed patient information forms attached.
- ____ A current list of eye drops and medications.
- ____ Current Insurance Cards.
- ____ If your insurance requires a referral to see a Specialist, please make sure to have your Primary Care Physician issue this for you.
- ____ Co-pays for a “Specialist” as noted on your insurance cards.
- ____ A valid picture Identification card such as a Driver’s License.
- ____ Contact lens information, brand, power of lenses and solution.

** Please note:**
Without a proper referral, payment will be due at the time of the office visit.
If your insurance is non-participating, payment will be collected at the time of the office visit.
For Refractions and Contact lens fittings, payment will be collected at the time of the office visit.

Please feel free to contact us with any questions, 215-345-5144.

Appointment date & time: ____________________________________________
REGISTRATION FORM I

Please complete this form to assure all of our billing and personal records are accurate. Please print. Thank you.

Patient Name: ________________________________ DOB: __________________

Address: ________________________________ Email: __________________

City/State/Zip: ________________________________ SS#: __________________

Employer: ________________________________ Occupation: __________________

Phone: ____________________ Cell: __________________ Work: __________________

Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed Sex: □ Male □ Female

Who may we thank for referring you here today?

Name: ____________________________________________

Referring Physician: ______________________ Phone: __________________

Primary Care Physician: ______________________ Phone: __________________

Present Optometrist: ______________________ Phone: __________________

Review of Systems Medical History Please circle all that apply

GI: nausea/vomiting/diarrhea/weight loss/other__________

Heart/Lungs: asthma/chest pain/shortness of breath/cough/irregular heart beat/other_____ 

GU: pain on urination/incontinence/increase in urinary frequency/other__________

HEENT: headaches/hearing loss/sore throat/other__________
Skeletal: joint pain/muscle pain/back pain/other ____________

Skin: rashes/bruises/new skin lesions/other ____________

Neuro: headaches/seizures/dizziness/numbness or tingling/other ____________
Endocrine: thyroid/excessive thirst or urination/hot or cold intolerance/other _____

Physician Signature: ______________________________
REGISTRATION FORM II

Patient Name: ___________________________ DOB:____________________

ROS, PAST MEDICAL, FAMILY AND SOCIAL HISTORY

Medical History
Please check appropriate boxes.

☐ Diabetes  ☐ Heart Disease  ☐ Stroke  ☐ Cholesterol  ☐ Thyroid
☐ High Blood Pressure  ☐ Asthma  ☐ MS  ☐ Cancer  ☐ Kidney  ☐ Arthritis
☐ Blindness  ☐ Deafness  ☐ Cataracts  ☐ Glaucoma  ☐ Macular Degeneration
☐ Retinal Detachment  ☐ Corneal Dystrophy

Family History  Please check appropriate boxes.

☐ Diabetes  ☐ Heart Disease  ☐ Stroke  ☐ Cholesterol  ☐ Thyroid
☐ High Blood Pressure  ☐ Asthma  ☐ MS  ☐ Cancer  ☐ Kidney  ☐ Arthritis
☐ Blindness  ☐ Deafness  ☐ Cataracts  ☐ Glaucoma  ☐ Retinal Disease________

Social History

Do you smoke cigarettes/cigars:_____  How much?_____  Yrs. smoked?_____

Do you drink alcohol?______  How much? _____  How often?_____

Do you take any legal or illegal drugs _____yes  _____no.  If so please list them on the enclosed Medication List.

Please note: this is important for interactions with anesthetic or prescriptions we may prescribe or use during your visit.

Allergies: ☐ None  ☐ Iodine  ☐ Fluorescein  ☐ Latex  ☐ Penicillin  ☐ Sulfa  ☐ Anesthetic  ☐ Other

Any other information that you feel is important for our doctors to know, please list here

Physician Signature: ____________________________________________
REGISTRATION FORM III

Patient Name: _______________________________ DOB:____________________

List all previous surgeries and dates other than eye surgery:

List all previous eye surgeries/treatments/lasers and dates.

Cataract surgery: Right eye (date)__________   Left eye (date)__________

Yag Capsulotomy: Right eye (date)__________   Left eye (date)__________

Diabetic Retinopathy:
   Laser_______   Right eye (date)__________   Left eye (date)__________

Glaucoma:
   Laser_______   Right eye (date)__________   Left eye (date)__________

Retinal surgery or treatment:_____________________Other:___________________

INSURANCE INFORMATION

PRIMARY INSURANCE: __________________________ EFF. DATE______________
ID NUMBER__________________ GROUP NUMBER__________________

SUBSCRIBER INFORMATION (If other than yourself):
Name:_____________________________ DOB___________ Relationship____________

SECONDARY INSURANCE: __________________________ EFF. DATE______________
ID NUMBER____________________________ GROUP NUMBER___________________

IN CASE OF EMERGENCY

Name of Contact: ___________________________ Relationship:________________
Home Phone:_____________________________ Alternate Number: ______________

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I authorize Galiani Ophthalmology Associates or my insurance company to release any information required to process my claims.

SIGNATURE:_____________________________________DATE:___________________
AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I ________________, hereby authorize Galiani Ophthalmology Associates to release my Personal Health Information to the following:

Name                                    Relationship

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

I give permission for messages regarding my diagnosis, results of testing, answers to questions or any other pertinent information regarding my health to be left on my answering machine.

Patients’ signature: ___________________________    Date: ________________
Witness: _________________________________________    Date: ________________

Our notice of privacy policy provides information about how we may disclose protected health information about you. The notice contains a patient rights section describing your rights under law. You have the right to review our notice before signing. The terms of our notice may change. If we do change our notice, you may obtain a copy by contact our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction but if we do, we shall honor that agreement.

In signing this form, you consent to our use and disclosure of protected health information. You have the right to revoke this consent in writing, signed by you. A revocation will not affect any disclosures we have already made in reliance to your prior consent. The practice provides this form to comply with the Health Insurance Portability Act of 1996 (HIPPA Act).

Signature: ___________________________________________  Date: ____________________

Relationship to patient if other than patient: ____________________________________
# MEDICATION LIST

**PATIENT NAME:** ____________________________  **DOB:** ________________

**Pharmacy Name:** __________________________  **Phone #:** ________________

**Pharmacy Address:** ____________________________________________________

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**Galiani Ophthalmology Associates**

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