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: _____

Galiani Ophthalmology ASSOCIATES

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: _____

Galiani Ophthalmology ASSOCIATES

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: _____

Galiani Ophthalmology ASSOCIATES

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:_____

MEDICATION NAME	DOSAGE
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____