KALYANI EYE CARE

Patient Registration Form

Sachin D. Kalyani
7556 Teague Road, Suite 410
Hanover, MD 21076
PHONE: 410-782-3233 | **FAX:** 410-799-8585

Patient Registration			
Last Name:	First Name:	Middle:	Prefix: Mr. Mrs. Ms. Dr. (please circle)
Birth date:	SS #:	Sex: Male Female (please circle)	
Address (or PO Box):			
City:	State:	Zip:	
Home Phone:	Cell Phone:	Work Phone:	
Email Address:	May we leave appointment reminder phone messages? Yes No (please circle)		
Preferred Method of contact: (please circle)	Home Cell Work Email		
Emergency Contact Name:	Phone:	Relationship:	

Patient Information				
Marital Status (please circle):	Single	Married	Divorced	Widowed Life Partner
Preferred Language (please circle):	English	Spanish	Other	
Ethnicity (please circle):	Hispanic or Latino	Not Hispanic or Latino	Other	
Race (please circle):	Native American or Alaskan Native	Asian	Black or African American	
	Caucasian/White	Native Hawaiian or Other Pacific Islander	Multiracial	Other

Responsible Party ( ) same as above			
Last Name:	First Name:	Middle:	Prefix: Mr. Mrs. Ms. Dr. (please circle)
Birth date:	SS#:	Sex: Male Female (please circle)	
Address:		Phone:	

Physician Information	
Primary Care Physician:	Phone:
Referring Physician:	Phone:
Other Physician:	Phone:

I, the undersigned, voluntarily consent to treatment by the physician(s) and staff of Kalyani Eye Care, LLC. I also voluntarily consent to the use and disclosure of my protected health information for treatment, payment and operations and such other purposes that are permitted under the federal Health Insurance Portability and Accountability Act without a written authorization. I accept that I am financially responsible for all services rendered on my behalf by the Practice. For those insurance plans for which the Practice accepts assignment, I accept personal responsibility for all co-payments, deductibles and non-covered services, as dictated by my insurance coverage, plus any collection costs for amounts personally owed by me, including attorney fees if necessary. I authorize payment directly to the Practice for services for which the Practice accepts assignment. A copy of this agreement may be used in place of the original. I certify that the information stated on this form is correct.

Signature: _____ Date: _____

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Pharmacy Information

Pharmacy: City: Phone:

Female Only

Are you pregnant? Yes No Are you breastfeeding? Yes No

Medications

Please list any eye drops you may be using currently: **None**

Medication	Eye (Right, Left, Both)	How many times a day?

Please list any other medications you may be taking (enter dosages if known)**:** **None** **See Attached List**

Please list known allergies to medications: **No known allergies**

Review of Systems

Have you experienced any of these symptoms within in the last 3 weeks? (Circle those that apply) **NONE**

General:	Heart:	Metabolic/Endocrine:	Skin:
Fatigue Fever Weight Gain Weight Loss	Chest Pressure/Discomfort Irregular Heartbeat Palpitations	Cold Intolerance Heat Intolerance Increased Thirst	Rash Skin Lesions Sores
Ear/Nose/Throat:	**Gastrointestinal:**	**Neurological:**	**Musculoskeletal:**
Hearing Loss Nasal Congestion Sinus Problems	Abdominal Pain Nausea Vomiting	Dizziness Headache	Joint Pain Joint Stiffness Muscle Weakness
Breathing:	**Genital/Urinary:**	**Psychological:**	**Blood:**
Cough Shortness of Breath Wheezing	Pain with Urination Genital Lesions Genital Sores	Depressed Mood Emotional Changes Nervousness	Easy Bleeding Easy Bruising
			Allergies:
			Seasonal Allergies

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Medical Questionnaire

Do you wear glasses? **Yes** **No**	Do you wear contacts? **Yes** **No**

Previous eye problems, surgeries or injuries: _____

_____

_____

Past Medical History

Please circle those that apply: **None**

Allergies	Cancer	Headache/migraine	Seizure
Anxiety	COPD/emphysema/bronchitis	Heart Disease	Stroke
Arthritis (osteo or rheumatoid)	Depression	Hepatitis	Thyroid Disease
Asthma	Diabetes	High blood pressure	Oral or genital sores
Enlarged Prostate	High Cholesterol	Bowel Disease	HIV/AIDS
Blood Clots	Acid reflux/GERD	Kidney Disease	Other:

Family Medical History

Known family history of the following: **None** **Adopted**

Macular Degeneration Relation: _____

Glaucoma Relation: _____

Other Eye Disease Relation: _____

Social History

What is your profession?

Do you smoke? **Yes** **No** **Formerly**

How many packs a day? _____ How many years did you smoke?_____

Do you drink alcohol? **Yes** **No** **Formerly**

How many drinks?_____ per Day / Week / Month / Year (please circle)