PETER L. MENGER, M.D., P.C., F.A.C.S.
EYE PHYSICIAN AND SURGEON
(718) 386-1818 (516) 775 4551

PATIENT REGISTRATION AND INFORMATION FORM

LAST NAME _____ FIRST NAME _____ M I. ____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

TELEPHONE # _____ CELLULAR # _____

SOCIAL SECURITY # _____

DATE OF BIRTH _____ AGE _____ SEX _____ MARITAL STATUS _____

PHARMACY NAME _____ PHARMACY ADDRESS _____

PHARMACY PHONE # _____ PHARMACY FAX # _____

Language: __ Patient declined to answer __ English

Race: __ American Indian/Alaskan Native __ Black or African American

__ Hawaiian or Pacific Islander __ Patient refused to answer __ Unknown __ White

Ethnicity: __ Hispanic or Latino __ Non-Hispanic or Latino __ Patient refused to answer

PRIMARY CARE PHYSICIAN _____

EMERGENCY CONTACT NAME _____ # _____

Please answer the following questions about your medical status and history:

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING _____

_____

_____

ARE YOU ALLERGIC TO ANY MEDICATIONS, DO YOU HAVE ANY ALLERGIES? _____ IF YES, PLEASE LIST

_____

_____

HAVE YOU EVER BEEN TREATED FOR ANY MEDICAL CONDITIONS?
(e.g., diabetes, high blood pressure, arthritis, etc.) If yes, please specify: _____

_____

_____

HAVE YOU EVER HAD ANY EYE DISEASE? (e.g., glaucoma, cataract, retinal detachment, etc.)

If yes, specify: _____

_____

Patient Name: _____ Date of Birth: _____

HAVE YOU EVER BEEN HOSPITALIZED OR HAD ANY SURGERY?

If yes, please provide date and reason: _____

_____

DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING PROBLEMS

	Yes	No	If yes, explain
Ear/nose/throat Problems (e.g. hearing loss, sinus problems, sore throat, runny nose)	___	___	_____
Heart Problems (e.g. chest pain, irregular heartbeat, dizziness)	___	___	_____
Respiratory Problems (e.g. shortness of breath, wheezing, coughing, asthma)	___	___	_____
Gastrointestinal Problems (e.g. heartburn, nausea, jaundice/hepatitis)	___	___	_____
Urinary Problems (e.g. pain or discomfort, blood in urine, kidney stones, history of STD)	___	___	_____
Musculloskeletal Problems (e.g. arthritis, joint pain, swollen joints)	___	___	_____
Neurological Problems (e.g. numbness, weakness, headaches, paralysis, seizures)	___	___	_____
Psychiatric Problems (e.g. depression, anxiety, difficulty sleeping)	___	___	_____
Chronic fever, unexpected weight loss/gain, fatigue	___	___	_____
Skin Problems (e.g. rashes, lesions, hives/eczema)	___	___	_____
Endocrine (e.g. increased thirst, urination, sweating, hunger, fingernail changes)	___	___	_____
Blood/Lymph nodes (e.g. easy bruising, gums bleeding easily, prolonged bleeding, heavy aspirin use)	___	___	_____

FAMILY AND SOCIAL HISTORY

Do any medical or eye diseases run in your family (e.g. diabetes, high blood pressure, cancer, glaucoma, macular degeneration)

Yes ___ No ___ If Yes, please explain: _____

_____

Do you smoke? If Yes, how much? _____

Did you ever smoke? Yes ___ No ___

Do you drink alcohol? If Yes, how much? _____

WHO REFERRED YOU TO OUR OFFICE? _____

EMPLOYER _____ WORK # _____ OCCUPATION _____

_____

M.D. Signature Date

INSURANCE INFORMATION FORM

PLEASE COMPLETE ALL APPLICABLE SECTIONS
SIGN AND DATE AT BOTTOM OF PAGE

PRIMARY INSURANCE COMPANY NAME _____

ADDRESS _____

_____

TELEPHONE [_____] _____ - _____ POLICY HOLDER'S RELATIONSHIP TO YOU _____

POLICY HOLDERS NAME _____ DATE OF BIRTH_____ / _____ / _____ SEX: M / F

POLICY ID NUMBER _____ GROUP NUMBER / NAME _____

SECONDARY INSURANCE COMPANY NAME _____

ADDRESS _____

_____

TELEPHONE [_____] _____ - _____ POLICY HOLDER'S RELATIONSHIP TO YOU _____

POLICY HOLDERS NAME _____ DATE OF BIRTH_____ / _____ / _____ SEX: M / F

POLICY ID NUMBER _____ GROUP NUMBER / NAME _____

I UNDERSTAND THAT, UNLESS OTHER ARRANGEMENTS ARE MADE IN ADVANCE, OR WHERE APPLICABLE OR FEDERAL OR STATE LAWS SUPERSEDE, ALL FEES ARE THE RESPONSIBILITY OF THE PATIENT AND ARE DUE AT THE TIME OF SERVICE.

I UNDERSTAND THAT I AM RESPONSIBLE FOR YOUR FEES FOR SERVICES. A SERVICE CHARGE OF 1.5% PER MONTH 18% PER YEAR WILL BE ADDED TO ANY BALANCE DUE MORE THAN 30 DAYS BEYOND COMPLETION OF TREATMENT. 33% WILL BE ADDED TO YOUR OUTSTANDING BALANCE TO COMPENSATE FOR COLLECTION FEES.

IF YOU ARE A MEMBER OF AN INSURANCE PLAN IN WHICH WE ARE A PARTICIPATING DOCTOR OR PREFERRED PROVIDER, WE WILL ACCEPT THE FEES PROVIDED BY THAT PLAN. THE PATIENT IS RESPONSIBLE FOR THE CO-PAYMENT AND/OR THE DEDUCTIBLE. IF A REFERRAL IS REQUIRED WITH THE PATIENTS INSURANCE PLAN IT IS THE PATIENT'S RESPONSIBILITY TO OBTAIN THAT REFERRAL, IF A CLAIM IS DENIED DUE TO NO REFERRAL THE PATIENT IS RESPONSIBLE FOR PAYMENT FOR SERVICES RENDERED.

PLEASE NOTE THE PATIENT IS ALSO RESPONSIBLE FOR FILING ANY SECONDARY INSURANCE CLAIMS.
I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS MEDICAL CLAIMS FOR PROFESSIONAL SERVICES RENDERED IN THIS OFFICE.

Patient's Signature _____ Date: _____ / _____ / _____

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Please provide your email address: _____

SIGNATURE ON FILE
_____ Beneficiary Name (print) _____ Medicare Number
1. MEDICARE I request that payment of authorized Medicare benefits be made on my behalf to_____, for services furnished me by _____. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. _____ accepts the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier. _____ _____ Beneficiary Signature Date
2. MEDIGAP If a MediGap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made either to me or on my behalf to _____. _____ _____ Beneficiary Signature Date
3. OTHER INSURANCE I hereby authorize payment of my medical and surgical insurance benefits to _____. I understand I am financially responsible for any charges whether or not paid by said insurance. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to _____. I authorize _____ to release any information required to process any and all claims for reimbursement on my behalf. A copy of this authorization may be used in place of the original. _____ _____ Beneficiary Signature Date