CHICAGO EYE SPECIALISTS
Raj K. Goyal, MD, MPH, FACS
7456 S STATE RD, SUITE 302
BEDFORD PARK IL 60638

TEL - 773-873-0052
FAX - 773-873-0054

NEW PATIENT INFORMATION

Email: ____

Personal Information
(PLEASE PRINT)

Name: Date:__
Date of Birth:________________Age ________M/F_______ Soc Security#______________________
Address city state zip
Phone: Home( )______________________________
Work( )________________________________
Occupation:_________________________________Employer:________________________________
Address____Phone:______________________
Marital Status: □ Single □ Married □ Widowed □ Divorced
Spouse Name:______________________________________
Employer:___________________________
Address:____Phone:_________________

Complete If under 18 years or a Student

Name of Father:
Employer:___________________________

Name of Mother:
Employer:__________________________

Referred By: □
Friend/Relative___________________________Doctor:__________________________
□ Yellow pages □ Television □ Newspaper □ Other:_______________________________________

Insurance Information

□ Medicare#_____________________________________□ Medicaid#
□ Workers Comp: (Job injury) to whom is bill to be sent
to?____________________________________
____
___
□ Other Medical
Insurance:____
Group#____________________________
ID#____
Name/Address 2nd
insurance____
Are you personally responsible for the payment of your fees? □ Yes □ No If not, who is?
Name:____
Relationship____________DOB___________

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Who to notify in emergency (nearest relative or friend)?

Name:_______________________________________
Relationship___________________________
Address____city__________state________zip________
Phone: Home( )_____________________________
Work( )______________________________

Financial Assignment and Agreement:

1. Please remember that insurance is considered a method of reimbursing the patient for fee paid to the doctor and others pay a percentage of the charge. It is your **responsibility** to pay any deductible
amount, co-insurance or any other balance not paid for by your insurance.
2. I request that payment of authorize Medicare and/or insurance benefits be made on my behalf for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration, its agents, or any insurance carrier. I may have, any information needed to determine these benefits payable for related services.
3. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original, I understand that I am Financially responsibility for all charges Whether or not paid by said insurance.
I hereby authorize said insurance to release all information necessary to secure the payment.

Signed(Patient or parent if minor)_____________________________________
Date______________

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MEDICAL HISTORY

Name: ____

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

1. Have you ever been treated for any medical conditions (diabetes, high blood pressure, arthritis, etc.)
□ Yes □ No If Yes, Please explain
____

2. Have you ever had any eye disease(glaucoma, cataract, wandering eye, lazy eye, retinal detachment)
□ Yes □ No If Yes please explain
____

3. Have you ever had any surgery?
□ Yes □ No If yes please explain
____

4. Have you ever been hospitalized within the last 2 years?
□ Yes □ No If yes, Please provide date and reason
____
____

5. Do you take any medications? □ Yes □ No.
____
If yes please list,____

6. Do you take any eye medication? □ Yes □ No.
____
If Yes please list.
____

<u>Review Of Systems</u>

Do you currently have any of the following problems?
If you say yes to any of the question, Please explain

Chronic fever, unexpected weight loss/gain, fatigue? Yes □ No □
Explain:
____

Ear/nose/throat problems(hearing loss, sinus problems, sore throat Yes □ No □
Explain:
____

Heart problems(shortness of breath, wheezing, coughing: Yes □ No □
Explain:___________________

Gastrointestinal problems(heartburn, abdominal pain, diarrhea, vomiting: Yes □ No□
Explain:
____

Urinal problems(pain or discomfort, blood in urine) Yes □ No□ Explain: _______________________

Skin problems(rashes, excessive dryness) Yes □ No □
Explain:_______________________________

Musculoskeletal problems(muscles aches, joint pain, swollen joints) Yes□ No □

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Explain:____

Neurologic problems(numbness, weakness, headaches, paralysis) Yes□ No □
Explain:____

Psychiatric problems(depression, anxiety) Yes □ No □
Explain:____

Family and Social History
Do any medical or eye diseases run in your family (diabetes, high blood pressure, cancer, glaucoma, Macular degeneration) Yes □ No □ Explain:____
____

Do you Smoke? If Yes how much? __________ Do you Drink? If Yes how much?________________
If Employed, how many hours per week do you work?
____

Comments:

Signature: ____ Date:

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ACKNOWLEDGMENT OF THE NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You may review our notice available from our Front Desk staff. As provided in our notice, the terms of this notice may change.

If we change our notice, you may obtain a revised copy from our Front Desk staff.

I have read the above paragraph and fully agree to the statement therein.
I acknowledge my agreement by signing below.

____ ________________
Patient Date

____ ________________
Parent or Guardian (if patient is under 18 years of age) Date