CHICAGO CORNEA CONSULTANTS, Ltd.
Diseases and Surgery of the Eye
Cornea and External Diseases
Refractive Corneal Surgery

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Brian D. Doyle, O.D.

Patient Name: _____ **Date:** _____

Dear Patient,
Please fill out the form below, the best that you can, so that we can obtain information about the pharmacy you would like us to use for our electronic prescribing for your medications.
Thank you.

Pharmacy Name**:**

Street Address/Corner of: _____

City / State: _____

Phone Number: _____

Referring Eye Doctor Name**:** _____

City / State: _____

Phone Number: _____

Primary Care Physician Name**:** _____

Practice Name: _____

City / State: _____

Phone Number: _____

Staff Only:

Patient Account #: _____

Tech. Initials when completed: _____

- ☐ PCP not in system
- ☐ Referring Dr. not in system
- ☐ PCP/Ref. Dr. Entered by _____

806 Central Ave. ● Suite 300 ● Highland Park, IL 60035 ● (847) 432-6010 ● Fax: (847) 432-8241
1585 N. Barrington Rd., Doctors Bldg. #2 ● Suite 502 ● Hoffman Estates, IL 60169 ● (847) 882-5900 ● Fax: (847) 882-6028
Rush University Med. Center, 1725 W. Harrison St. ● Suite 928 ● Chicago, IL 60612 ● (312) 942-5300 ● Fax: (312) 942-4045
Internet address: www.chicagocornea.com

(Please use BLACK ink only) **PATIENT INFORMATION SHEET**

Mr/Mrs/Ms/Dr _____
Last Name First Middle Initial

Address _____
Street City State Zip

Home Phone (___)_____ Birthday _____ Age _____ SS# _____
Month – Day – Year

Cell Phone (___)_____ E-mail Address _____

Responsible party (if other than above) _____ Ph (___)_____ Birthdate _____ SS# _____

How did you learn about our practice? _____ Medical Doctor/City _____

Allergies to any medications _____

Patient's Employer _____ ☐ Full-time ☐ Part-time ☐ Not Employed ☐ Self Employed ☐ Retired

Patient's Occupation _____ Business Address _____ Business Phone (___)_____

Patient's Marital Status (circle) S / M / Div. / Wid. / Partner *Name of spouse/partner_____

Spouse/Partner's Employer _____ Business Phone (___)_____

Spouse/Partner's Business Address _____

Patient's payment information for first visit: ☐ Check ☐ Cash ☐ Credit Card ☐ Insurance

Primary Insurance/Mailing Address _____

Name of Insured (Subscriber) _____ Member ID# _____ Group # _____

SS# _____ Birthdate _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____
Month – Day – Year

Secondary Insurance/Mailing Address _____

Name of Insured (Subscriber) _____ Member ID# _____ Group # _____

SS# _____ Birthdate _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____
Month – Day – Year

Please list an **EMERGENCY CONTACT**, preferably not living with patient (other than responsible party):

Contact name _____ Relationship to pat.: ☐ Spouse ☐ Child ☐ Parent ☐ Friend ☐ Neighbor ☐ Other

Address _____ Phone (___)_____

Our goal is to provide you with the best medical care available. In order to achieve our goal and minimizing escalating administrative costs, we ask for your understanding and cooperation regarding the following payment/insurance policies:

1. **We ask that payments be made at the time of your visit unless other arrangements have been made in advance.**
2. **If you are a member of an HMO or POS plan, you need to have a VALID referral for each office visit and surgical procedure. Please call our office in advance to make sure you have the necessary forms and authorization.**
3. **It is our policy to render periodic statements for services on a monthly basis. In the event our statements for services are not paid within sixty (60) days after you received an invoice, we reserve the right, at our option, to charge interest on the balance due, at a rate of one-and-one-half (1½) percent each month.**
4. **Our payment policy also requires that payments for Refraction are expected at the time of service for all Medicare patients as well as for those patients whose insurance does not cover Refraction.**

Non-Medicare patients:

I hereby authorize payment directly to Chicago Cornea Consultants, Ltd. of the surgical and/or medical benefits, if any, otherwise payable to me for services as rendered. I authorize the physician to release such medical or other information regarding this treatment or subsequent treatment relative to this injury or illness for the purpose of obtaining reimbursement on my behalf for services provided by the physician, or, to others involved in my care.

Medicare patients:

I request that payment of authorized Medicare benefits be made on my behalf to Chicago Cornea Consultants, Ltd. for any services furnished me by those physicians. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or benefits payable for related services.

I request that payment of authorized "Medigap" benefits be made to Chicago Cornea Consultants, Ltd. for any service furnished me by those physicians. I authorize any holder of medical information about me to release to my Medigap insurer any information needed to determine these benefits or the benefits payable for related services.

I accept and understand the payment/billing policies as outlined above.

Signed (Patient or Guardian) _____ Date _____

MEDICAL HISTORY QUESTIONNAIRE - *Adapted from the American Academy of Ophthalmology*

Name: _____

REVIEW OF SYSTEMS:

Primary reason for today's (first) visit: _____

Do you presently have any problems in the following areas? If "YES", give an explanation.

	YES	NO	EXPLANATION OF PROBLEM
Eyes			
Loss or blurred vision	[ ]	[ ]	_____
Loss of side vision, double vision	[ ]	[ ]	_____
Itching, burning, or discharge	[ ]	[ ]	_____
Redness	[ ]	[ ]	_____
Gritty feeling, dryness or tearing	[ ]	[ ]	_____
Glare/light sensitivity, or halos	[ ]	[ ]	_____
Eye pain or soreness	[ ]	[ ]	_____
Infection of eye lashes or lid, styes	[ ]	[ ]	_____
Ears, nose, mouth, throat	[ ]	[ ]	_____
Cardiovascular, (heart, blood vessels)	[ ]	[ ]	_____
Respiratory (lungs/breathing)	[ ]	[ ]	_____
Gastrointestinal (stomach/intestines)	[ ]	[ ]	_____
Genitourinary (genitals/kidney/bladder)	[ ]	[ ]	_____
Musculoskeletal (muscles/joints)	[ ]	[ ]	_____
Integument (skin/breast)	[ ]	[ ]	_____
Neurological	[ ]	[ ]	_____
Psychiatric	[ ]	[ ]	_____
Endocrine (hormones, glands)	[ ]	[ ]	_____
Hematologic/Immunologic (blood)	[ ]	[ ]	_____
Seasonal allergies (hay fever, etc.)	[ ]	[ ]	_____

PAST HISTORY (EYE)

	YES	NO	
Eye drops currently in use: (list)	[ ]	[ ]	
_____			
_____			
Allergies to eye drops	[ ]	[ ]	List drops you are allergic to: _____
History of cataract, glaucoma	[ ]	[ ]	_____
History of cross/lazy eye	[ ]	[ ]	_____
Eye injury or other disease	[ ]	[ ]	_____
Eye surgery	[ ]	[ ]	_____
Has your glasses/contact lens prescription			_____
been stable for at least one year?	[ ]	[ ]	_____

OVER PLEASE

PAST HISTORY (MEDICAL)

List any medications (other than eyedrops) that you are currently using: _____

_____

_____

List all major illnesses: Diabetes _____ Hypertension _____

Other: _____

_____

List any major surgical procedures: _____

_____

Do you have any medication allergies? [ ] NO [ ] YES Penicillin Sulfa

List other medication allergies: _____

_____

FAMILY HISTORY

	YES	NO	EXPLANATION/RELATIONSHIP
OCULAR			
Blindness	[ ]	[ ]	_____
Cataract	[ ]	[ ]	_____
Glaucoma	[ ]	[ ]	_____
Macular degeneration	[ ]	[ ]	_____
Retinal detachment	[ ]	[ ]	_____
Keratoconus	[ ]	[ ]	_____
MEDICAL			
Diabetes	[ ]	[ ]	_____
Arthritis, lupus, etc.	[ ]	[ ]	_____
Other (list)	[ ]	[ ]	_____

SOCIAL HISTORY

	YES	NO	EXPLANATION
OCULAR			
Have you ever tried to wear contacts?	[ ]	[ ]	_____
Did you have problems with contacts?	[ ]	[ ]	_____
Vision causes problems with:			
❑ Driving ❑ Night vision ❑ Reading ❑ Sports/Outdoor activities			
GENERAL			
Do you drink alcohol?	[ ]	[ ]	How much per day? _____
Do you smoke?	[ ]	[ ]	
Have you ever had a blood transfusion?	[ ]	[ ]	
Have you ever had contact with a person who had a sexually transmitted disease?	[ ]	[ ]	

Patient's signature: _____ Date: _____

History reviewed [ ] No changes [ ] Additions as noted

Physician's signature: _____ Date: _____

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ACKNOWLEDGMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

I understand that as part of my healthcare, Chicago Cornea Consultants, Ltd. originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, billing information and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third party payer can verify that services billed were actually provided,
- A tool for routine health care operations such as assessing quality and reviewing the competence of healthcare professionals, and
- A means by which payment for services can be made.

I acknowledge that Chicago Cornea Consultants, Ltd. has provided me with a copy of its NOTICE OF PRIVACY PRACTICES ("NOTICE") that provides a more complete description of information uses and disclosures.

I understand that for convenience or necessity I would like my health information available to the following friends or family members:

_____ _____

_____ _____

_____ _____
Patient Signature Date

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