Chirag S. Shah, M.D., LLC **Angana N. Shah, M.D., LLC**
Ophthalmologists
2999 Princeton Pike, Suite 1, Lawrenceville, NJ 08648
Phone: (609) 883-3000 Fax: (609) 423-0095 Website: shaheye.com

CONFIDENTIAL
Patients under 18 must be accompanied by an adult.

PATIENT REGISTRATION

Last Name: _____ First Name: _____ MI: _____
Address: _____ Apt#: _____ City: _____
State: _____ Zip Code: _____ Home Phone: _____
Birthdate: _____ Age: _____ Sex: ___ Cell Phone: _____
Employer: _____ Work Phone: _____
Marital Status: _____ Social Security #: _____
Emergency Contact Person's Name: _____ Phone: _____
Referred By: _____ Phone: _____
Medical Doctor: _____ Phone: _____
Pharmacy No: _____

INSURANCE INFORMATION

Please present all insurance ID cards and referrals to the receptionist, without it services cannot be rendered according to the insurance law.
Pateint is responsible to provide the payment and co-payment when services are rendered.

Primary Insurance Name _____
Policy Holder: _____ Birth Date: _____
Relationship: _____
POLICY #:_____ GROUP #: _____

SECONDARY INSURANCE NAME: _____
POLICY HOLDER: _____ Birth Date: _____
RELATIONSHIP: _____
POLICY #:_____ GROUP #: _____

1. I am responsible to provide the referral, where required.
2. I am responsible to provide the payment and co-payment when services are rendered.
3. I understand that I am financially responsible to pay for any balance not covered by my Primary insurance or Secondary insurance, such as deductible, co-insurance and co-payment and any other services that are not covered by my insurance plan.
4. I authorize the release of any medical information necessary to process an insurance claim.
5. I will immediately notify your office of any change in my address, phone number and insurance information.
6. I am responsible to inform you about the complete benefits provided by my insurance.

Patient Signature: _____ Date: _____
Guardian Signature: _____ Relationship: _____

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Patient Name: _____ Weight: _____ Height: _____ Age: _____
Are you currently pregnant? Yes No
Do you have a prescription drug plan? Yes No
Please list any drug allergies _____
Please list any other allergies _____
Please list present medications _____

MEDICAL HISTORY

Current illnesses: _____
Hospitalizations: 1._____ 2._____ 3._____
Operations: 1._____ 2._____ 3._____
Injuries: 1._____ 2._____ 3._____

SOCIAL HISTORY

Smoke: No Yes _____ packs per day.
Alcohol: No Yes _____ type & amount. Drugs: _____.

FAMILY HISTORY

(circle any that apply)

Glaucoma Macular Degeneration High Blood Pressure Diabetes
Thyroid Disease Stroke Tuberculosis Autoimmune Disease Eye Allergies
Headaches Bleeding Problems Cancer

Chief Complaint: What kind of problem are you seeing Dr. Shah for?

_____

How long have you had this condition? _____

REVIEW OF SYSTEMS (please circle Yes or NO and describe if Yes)

Yes No Neurological problems: _____
Yes No Ear/nose/throat problems: _____
Yes No Heart diseases: _____
Yes No Lung or breathing problems: _____
Yes No Endocrine disease (diabetes/thyroid etc): _____
Yes No Psychiatric problems: _____
Yes No Stomach/intestinal problems: _____
Yes No Skin diseases: _____
Yes No Kidney or urinary problems: _____
Yes No Ob/gyn problems: _____
Yes No Autoimmune disease (rheumatoid/lupus/sarcoid etc):_____

Other: _____

Patient Signature:_____ Date:_____

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Consent Agreement

I, _____ understand that as part of my healthcare, Dr. Shah's office originates and maintains health records describing my health history, symptoms. Examination and test-results, diagnoses, treatment, and any plans for future care of treatment. I understand that this information serves a:

- 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, and
- A tool for routine healthcare Operations, such as assessing quality, and reviewing the competence of healthcare professionals.

I understand and I have been provided with a Notice of Health Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken in reliance thereon.

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

_____

_____

I fully understand and accept/decline the terms of this consent.

Patient / Parent / Guardian Signature: _____

Date: _____

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INFORMATION REGARDING DILATING and other EYE DROPS

It is possible to have an allergic reaction to any eye drops. Also they may irritate the eye.

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye.

Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it's best if you make arrangements not to drive yourself.

Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

It is possible to have a corneal abrasion or scratch on the eye from today's exam.

I hereby authorize Dr. Shah and/or such assistants as may be designated by him/her to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

_____ _____

Patient (or person authorized to sign for patient) Date

REFRACTIONS (Prescription for glasses or contact lenses)

I _____ understand that if my insurance company does not cover charges for the refraction, I will be responsible for the charge of $ 35. Refraction is not considered part of a medical eye exam.

_____ _____

Patient (or person authorized to sign for patient) Date