

PATIENT REGISTRATION SHEET

THIS FORM MUST BE COMPLETELY FILLED OUT

Mr. Mrs. Miss. Ms. _____ Today's Date: _____

Home Phone: _____ Cell Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Sex: M F Marital Status: Single Divorced Married Widowed

Social Security Number: _____ — _____ — _____ Date of Birth: _____ / _____ / _____ Age: _____

Emergency contact 1: _____ Phone Number: _____ Relation: _____

Emergency contact 2: _____ Phone Number: _____ Relation: _____

Patients Employer: _____ Address: _____

City: _____ State: _____ Zip: _____ Work Phone: _____

Occupation: _____ Retired: Yes No

Patients Spouse: _____ Work Phone: _____

Social Security Number: _____ — _____ — _____ Date of Birth: _____ / _____ / _____ Age: _____

Employer: _____ Address: _____

City: _____ State: _____ Zip: _____ Work Phone: _____

Occupation: _____ Retired: Yes No

Referred By: _____ Phone: _____ Family Physician: _____ Phone: _____

Insurance: Please list the subscriber of the policy if other than the patient. List your primary Insurance Company first.

Primary (1): _____ Policy #: _____

Address: _____ Group #: _____

Subscriber: _____ Patient Spouse

Secondary (2): _____ Policy #: _____

Address: _____ Group #: _____

Subscriber: _____ Patient Spouse

➤ I authorize the release of any medical information necessary to process all claims:

Patients Signature: _____ Date _____

➤ I authorize the release of payment for medical benefits to my physician:

Patients Signature: _____ Date _____

MEDICAL HISTORY QUESTIONNAIRE

Name: _____

Date: _____

Date of Birth: ____/____/____

Date of Last Eye Examination: ____/____/____

List any medications you currently take (Rx and over-the-counter): _____

Do you have allergies to any medications? YES NO

If YES, List the medications: _____

List all major illnesses (glaucoma, diabetes, high blood pressure, heart attack, etc.) or injuries (concussion, etc.): _____

List any surgeries you have had (cataract, appendectomy): _____

Do you currently have any problems in the following areas? If YES, please provide additional information.

	YES	NO	DETAILS
EYES (poor vision, eye pain, tearing, redness, etc.)			
GENERAL / CONSTITUTIONAL (fever, heat stroke, weight loss, weight gain, unusually tired)			
EARS, NOSE, THROAT (hard of hearing, stuffy nose, ear ache, cough, dry mouth, etc.)			
CARDIOVASCULAR (high BP, racing pulse, etc.)			
RESPIRATORY (congestion, wheezing, short of breath, etc.)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)			
GENITAL, KIDNEY, BLADDER (painful, urination, frequent urination, impotence, yellow jaundice, etc.)			
FEMALES Are you pregnant? Nursing?			
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
SKIN (pimples, warts, growths, rash, etc.)			
NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
ENDOCRINE (diabetes, hypothyroid, etc.)			
BLOOD/LYMPH (bleeding, cholesterolemia, anemis, problems related to blood transfusion, etc.)			
ALLERGIC/IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)			

FAMILY HISTORY

(Mother, Father, Grandparents, Sibling)

Has any membr of your family had these diseases (check the boxes that apply)? YES NO UNKNOWN

Blindness Cataract Glaucoma Diabetes Hypertension Heart Disease Stroke Cancer Arthritis

Thyroid Disease or Other heritable disease: _____

SOCIAL HISTORY

Does your vision limit any activities of daily living (driving, reading, sports, work, etc)?..... YES NO

Have you ever had a blood transfusion?..... YES NO

Do you drink alcohol?..... YES NO If YES, how much? _____ daily weekly monthly

Do you smoke?..... YES NO If YES, how much? _____ pack(s) per: day week

If yes, how many years have you smoked? _____ I quit _____ years months days ago

Physician's Signature: _____

Date: _____

Murad A. Sunalp, M.D.



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**MURAD A. SUNALP, M.D.
SUNALP VISION CENTER
880 E MERRITT AVE., SUITE 109
TULARE, CA 93274**

Patient: _____ Date: _____

Acct#: _____

FINANCIAL POLICY

If your health care expenses are in part paid for by an insurance company, this office requires that you pay any **deductibles** or **co-payments** at the time services are rendered. We will bill your insurance plan for you for the portion of the fees that are covered by your insurance. However, if we are not contracted with your insurance, our policy dictates that payment is to be made in full at the time services are rendered. Dr. Sunalp is a participating provider with Medicare and various other insurance plans. Our patient care coordinators will be happy to discuss those plans with you.

A copy of your insurance card is required at the time of your first appointment and anytime your insurance changes for any reason. This information will be kept in your medical file. In the event surgery is required, verification of benefits will be obtained and you will be responsible for any services that are not covered by your insurance or applied to your deductible or co-pays.

Our office will bill your insurance plan directly as a service to you, but not in substitute of your primary responsibility for payment. Any fees, which are not paid by your insurance, are the **patient's responsibility**. You will receive a statement whenever there is a balance due by you. All patient due balances are expected to be paid within thirty (30) days of receipt of statements sent to you by our office. There will be a \$25.00 service charge for all returned checks.

Please remember that medical services are rendered to each patient at the requests of the patient; therefore, each patient is responsible to us for payment. Requests for alternative methods of payment will be reviewed on an individual basis. In an effort to insure that our patients receive the necessary care they need, every financial option will be considered prior to services being rendered to them.

Should you have any questions or concerns about you insurance or your account, please call our office (559)688-2020. We will be happy to help you in any way.

I have read the above policy and agree to comply with its provisions. I understand that if I am covered by an insurance plan, you office will bill them directly as a convenience to me, but that I will remain personally responsible for all charges for services rendered until they are paid in full.

POLICY NAME: _____ POLICY#: _____

PATIENT'S SIGNATURE: x _____ DATE: ____ / ____ / ____



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NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I understand that, under the health insurance Portability and Accountability Act of 1996 (“HIPPA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment of health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restriction.

Patient Name: _____

Relationship to Patient: _____

Signature: X _____ Date: ____/____/____

OFFICE USE ONLY

I attempted to obtain the patients signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:
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