Patient Registration

Please Print

Name:_____ Date:_____

Date of Birth:_____ Age:_____ Sex: ❑Male ❑ Female

Marital Status: ❑Single ❑Married ❑Divorced ❑Widowed ❑Separated

Social Security Number:_____

Mailing Address:_____
Number City State ZIP

Home Phone:_____ Business Phone: _____

Employer:_____

Employer Address:_____
Number City State ZIP

Spouse's Name:_____

Spouse's Employer: _____
Name Address Phone

Spouse's Social Security Number:_____

Name of nearest relative not living with you:_____

Address:_____ Phone: _____

Referred By:_____

Insurance Authorization and Assignment

I hereby authorize Russell D. Crain, M.D. to furnish information to insurance carriers concerning my illness and treatments, and I hereby assign to the doctor all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

> **"The information authorized for release may include information which may be considered a communicable or venereal disease which may include, but are not limited to, diseases such as Hepatitis, Syphilis, Gonorrhea, and the Human Immunodeficiency Virus, also known as Acquired Immune Deficiency Syndrome (AIDS)." Oklahoma Law (63 Oklahoma Statute, 1-502.2)**

Patient's Signature:_____ Date:_____

Insured's Signature:_____ Date:_____

A photocopy of this authorization and assignment shall be considered as valid as the original.

RUSSELL D. CRAIN, M.D., P.C.

11011 Hefner Pointe Drive, Suite B
Oklahoma City, OK 73120-5005

Consent to the Use and Disclosure of Health Information For Treatment, Payment, or Healthcare Operations

I understand that as part of my health and medical care, Russell D. Crain, M.D., P.C. originates and maintains medical and health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I further understand that this information serves as:

+ a basis for planning my care and treatment
+ a means of communication among the health professionals who contribute to my care
+ a source of information for applying my diagnosis and treatment information to my bill
+ a means for a third-party payer to verify that services were billed as actually provided

I further understand and agree that this agreement to release information shall apply to all information accumulated up to this date and to any information acquired in the future. And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals. This agreement to release future information shall remain in force until such time as I shall revoke it in writing.

I understand and have been provided with a PATIENT INFORMATION SHEET that provides a more complete description of information uses and disclosures. I understand that I have the right to review the PATIENT INFORMATION SHEET prior to signing this consent. I understand that Russell D. Crain, M.D., P.C., reserves the right to change his notice and practices, but that prior to implementation will mail a copy of any revised notice to the address I have provided. I understand 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 Russell D. Crain, M.D., P.C. is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent the organization has already taken action in reliance thereon.

By Oklahoma law we are required to notify you that the information authorized for release may include records which may indicate the presence of a communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS).

Information may be released to the following organizations for the indicated purpose. _____

_____ _____ _____

I request the following restrictions to the use and / or disclosure of my health information:

_____ _____

Signature of Patient or Legal Representative | Date Notice effective

Russell D. Crain, M.D., P.C._____accepts_____denies the restrictions imposed on release of information as stated above.

_____ _____

Signature / Title | Date

RUSSELL D. CRAIN, M.D.

PATIENT HISTORY

DO YOU HAVE PROBLEMS WITH ANY OF THE FOLLOWING:

Fatigue	❑YES	❑NO
Weight Loss	❑YES	❑NO
Fever	❑YES	❑NO
Ear/Nose/Throat	❑YES	❑NO
Heart	❑YES	❑NO
Circulation	❑YES	❑NO
Psychiatric	❑YES	❑NO
Endocrine/Hormonal	❑YES	❑NO
Breathing	❑YES	❑NO
Stomach/Intestine	❑YES	❑NO
Genital/Urinary	❑YES	❑NO
Skin	❑YES	❑NO
Muscle/Joint/Bone	❑YES	❑NO
Neurologic	❑YES	❑NO
Blood	❑YES	❑NO
Allergy/Asthma	❑YES	❑NO
Diabetes	❑YES	❑NO

Do you smoke? ❑YES ❑NO

If Yes, how many packs per day (_____packs/day)

Alcohol ❑YES ❑NO

Are you pregnant? ❑YES ❑NO

REVIEW OF SYSTEMS

OCULAR HISTORY

Glaucoma	❑YES	❑NO
Cataracts	❑YES	❑NO
Lazy Eye/Turned Eye	❑YES	❑NO
Retinal Detachment	❑YES	❑NO
Macular Degeneration	❑YES	❑NO
Dry Eye	❑YES	❑NO
Flashes/Floaters	❑YES	❑NO
Eye Injuries/Trauma	❑YES	❑NO
Iritis	❑YES	❑NO
Other Eye Conditions	❑YES	❑NO
Contact Lens Wear	❑YES	❑NO
Refractive Surgery (LASIK/PRK/RK)	❑YES	❑NO

FAMILY HISTORY

Diabetes	❑YES	❑NO
Heart Disease	❑YES	❑NO
Retinal Disease	❑YES	❑NO
Cataracts	❑YES	❑NO
Glaucoma	❑YES	❑NO
Retinal Detachment	❑YES	❑NO
Blindness	❑YES	❑NO

LIST PREVIOUS SURGERY

LIST ALL CURRENT MEDICATIONS

Including eye drops and over the counter medications

DRUG ALLERGIES