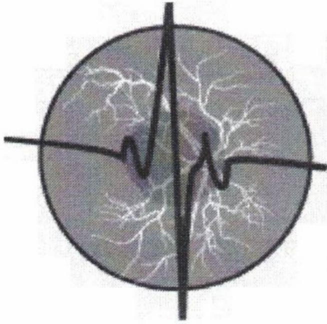


DIABETIC EYE
AND MACULAR DISEASE
SPECIALISTS LLC

Date:________________________

Patient Name:______________________________ DOB:_______________________

I hereby request that my medical records be released to:

Jeevan Mathura, MD

Providence Hospital, DePaul Building
1160 Varnum Street NE, Suite 208
Washington, DC 20017
202-506-3479 office
866-265-5635 fax

Patient Signature:_____________________________ Date:______________________

REGISTRATION

Last Name: ______________________________ First Name: ______________________________

Birth date: _____/_____/_____ Male / Female

Address: ______________________________ Apt: _____ City: ________________ Zip: ________

Please check box next to preferred contact method below

☐ Home Phone: (_____) ____________ ☐ Cell/Other: (_____) ______________

☐ E-mail: ______________________________ Marital Status: ________ Language: ______________

Occupation: ______________________________ ☐ Work Phone: (_____) ______________

Pharmacy: ______________________________ **Street:** ______________ **City:** ______________

Primary Medical Doctor: ______________________________

Referring Physician: ______________________________

Other Physician(s) involved in your care: ______________________________

In Case of Emergency, please list nearest relative/friend: Name: ______________________________

Relationship: ________________ Telephone: (_____) ______________

INSURANCE POLICY HOLDER:

If you are listed as a dependent on your insurance policy, please provide the subscriber's information:

Subscriber's / Guarantor's Name: ______________________________

Date of Birth: _____/_____/_____ Relationship: ______________________________

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Diabetic Eye DC to furnish information to insurance carriers, and any other physicians involved in my care, regarding my illness and treatments. I hereby assign to the physician all payment for medical services rendered to me. I understand that I am responsible for any amount not covered by the insurance company including co-pays, co-insurance and any deductible. I also understand that there will be a fee if I request a paper copy of my medical record.

Signature: ______________________________ **Date:** ______________

OPTIONAL INFORMATION:

(You may choose not to answer the following two questions by checking the "decline" box) ☐ DECLINE TO ANSWER

RACE: ________________ Ex.: White, Indian, Other **IF OTHER:** ______________

ETHNICITY: ☐ Not Hispanic/Latino ☐ Hispanic/Latino: ______________ (Country)

PROTECTED HEALTH INFORMATION (HIPPA)

I consent to the use and disclosure of my protected health information by Diabetic Eye & Macular Disease Specialists LLC, Jeevan R. Mathura, Jr., MD, and staff for the purpose of treatment, payment and healthcare operations only. I understand healthcare operations may include, among others, uses or disclosures relative to quality review, utilization review, medical necessity or legal review. Protected health information may include medical records, insurance and payment information and other information used in whole or in part, to make decisions about me. I understand that information about how my protected health information may be used, along with the complete Notice of Privacy Practices is available and that I may request a copy at any time.

I understand that all information is used in the care and treatment of my condition. No information, medical or otherwise, shall be used for commercial purposes or released to any party for purposes other than my healthcare. In addition, I also authorize the release of my information to the individuals listed on this page.

Patient's Signature: _______________ Date: _______________

Complete this section only when someone other than the patient is signing on their behalf

Patient's relationship to the signer: __________________

∆ Patient is unable to sign or acknowledge

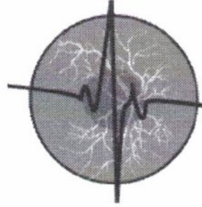
∆ Patient refuses to sign but was given the opportunity to acknowledge and sign

Signature: _______________ Date: _______________

Please list all family members and individuals who are involved in your care that we are authorized to share your health information with: ______________________________
____

Notice of Privacy Practices Acknowledgement Page:
We participate in the CRISP health information exchange (HIE) to share your medical records with your other health care providers and for other limited reasons. You have rights to limit how your medical information is shared. We encourage you to read our Notice of Privacy Practices and find more information about CRISP medical record sharing policies at www.crisphealth.org.

Providence Hospital, DePaul Professional Building
1160 Varnum Street, N.E., Suite 208
Washington, DC 20017
202-506-3479 (p)



MEANINGFUL USE ATTESTATION FORM

Patient Name: ________________

DOB: ________________________

Date: ________________________

We are now required to collect information on your language, race and ethnicity. If you prefer not to report this information, please feel free to mark "decline to report." Thank you for your cooperation.

Language Used to Conduct Appointment	**Race**	**Ethnicity**
Δ English	Δ Asian	Δ Hispanic / Latino
Δ Spanish	Δ Black or African American	Δ Not Hispanic or Latino
Δ Other:	Δ American Indian / Alaskan Native	Δ Unknown
Δ Decline to report	Δ Pacific Islander / Native Hawaiian	Δ Decline to report
	Δ White	
	Δ Other	
	Δ Decline to report	

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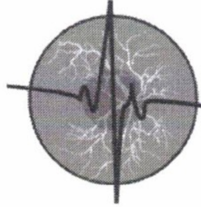

ACKNOWLEDGEMENT PATIENT WAS PROVIDED NOTICE OF PRIVACY PRACTICES

Patient Name: ________________

MRN: ________________________

Date: ________________________

I acknowledge I was given Diabetic Eye DC's Notice of Privacy Practices today.

____

[Patient Signature]

Witnessed by:

____

Diabetic Eye DC Staff Member Name / Title

If patient declines to sign, Diabetic Eye DC staff member signs below to confirm that Notice was offered to patient on the date listed above and patient declined to sign acknowledgement.

____

Diabetic Eye DC Staff Member Name / Title

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Please complete all sections, then sign and date at the bottom

SYMPTOMS

Place a mark in the box next to the symptom to indicate that you have any of the following:

EYES / VISION

	Which eye?		Which eye?		Which eye?		Which eye?
☐ Blurred Vision	________	☐ No Vision	________	☐ Pain	________	☐ Itching	________
☐ Distortion	________	☐ Curtain	________	☐ Watering	________	☐ Redness	________
☐ Shadow	________	☐ Flashes	________	☐ Light sensitive	________	☐ Dryness	________
☐ Dark Spot	________	☐ Floaters	________	☐ Double Vision	________	☐ **NONE**	

SYSTEMIC

☐ Shortness of Breath	☐ Dizziness	☐ Joint Pain	☐ Anxiety
☐ Numbness / Paralysis	☐ Chest Pain	☐ Hearing Loss	☐ Muscle Tenderness
☐ Headaches / Migraines	☐ Chills	☐ Cough / Wheezing	☐ Weight Change
☐ Diarrhea / Constipation	☐ Nausea / Vomiting	☐ Other: ________	☐ **NONE**

MEDICAL / FAMILY HISTORY

Place a mark in the box under "self" to indicate that you have any of the following conditions, mark "family" if someone in your family does and indicate who in the space provided:

EYES / VISION

Self	Family	Self	Which eye?
☐ Blindness	☐ ________	☐ Eye Injury	________ ☐ **NONE**
☐ Retinal Detachment	☐ ________	☐ Eye Infection	________
☐ Macular Degeneration	☐ ________	☐ Cataract Surgery	________
☐ Glaucoma	☐ ________	☐ Other Eye Surgery	________

GENERAL HEALTH

Self	Family	Self	Family	Self
☐ Heart Condition	☐ ________	☐ Thyroid	☐ ________	☐ Tuberculosis
☐ High Blood Pressure	☐ ________	☐ Arthritis	☐ ________	☐ HIV
☐ Vascular Disease	☐ ________	☐ Asthma	☐ ________	☐ Hepatitis (Type ____)
☐ Stroke	☐ ________	☐ Emphysema	☐ ________	☐ Pacemaker
☐ High Cholesterol	☐ ________	☐ Cancer	☐ ________	☐ Alcohol Use
☐ Kidney Disease	☐ ________	☐ Lupus	☐ ________	☐ Other: ________
☐ Diabetes	☐ ________	☐ Skin Condition	☐ ________	☐ **NONE**
☐ Dialysis – How often? ________		**Do you smoke?**	☐ Yes ☐ No	☐ Discontinued: ________

Please list any **ALLERGIES** to medications or other substances: ________________________

☐ **NONE KNOWN** ________________________

Please list **ANY MEDICATIONS** you are taking ________________________

☐ **NONE** ________________________

Please list any **surgical** procedures you have undergone: ________________________

☐ **NONE** ________________________

Primary reason you are here today? ________________________

The information that I have provided is current and accurate to the best of my knowledge.

Patient Signature: ________________________ **Date:** ________________

Appointment Cancellation Policy Agreement:

Diabetic Eye and Macular Disease Specialists LLC is committed to providing all of our patients with exceptional care. When a patient cancels without giving enough notice, they prevent another patient from being seen.

Please call us at (202) 506-3479 48 hours prior to your scheduled appointment to notify us of any changes or cancellations. **To cancel a *Monday* appointment, please call our office by 2:00 p.m. on *Friday*.** If prior notification is not given, you will be charged $25.00 for the missed appointment.

Please sign below to consent to these terms.

____

Client Signature

____

Date