Robert Mahanti, M.D.

PATIENT INFORMATION

Patient's Name:________________________________
Address:______________________________________
City:____
State:______________________ Zip Code:__________
Phone: ________________ Cell Phone:_____________
Social Security #:_______________________________
☐ Single ☐ Married ☐ Male ☐ Female

Birth Date:_____________
PERSONAL EMAIL: ___________________________________
I acknowledge that I will be receiving email notifications for appointment reminders and newsletters.
Please check box if you do not wish to receive email notifications ☐

SPOUSE OR LEGAL GUARDIAN

Name:____
Address:_______________________________________
City:____
State:_________________ Zip Code:_____________
Phone: ________________ Cell Phone:_____________
Social Security #:______________________________
☐ Single ☐ Married ☐ Male ☐ Female
Birth Date:________________________

EMPLOYMENT

Employer:_________________________________
Employer's Address:____________________________
City, State, Zip:_______________________________
Phone:___________________________ Ext._______

EMERGENCY CONTACT OR CARETAKER

Name:_______________________________________
Address:_____________________________________
Phone:______________________________________

Name of Primary Care Physician: ____
Who may we thank for referring you to our office? _______________________________ ☐Yellow Pages ☐Internet
Would you like to learn more about LASIK Surgery? ☐Yes ☐No ☐Maybe

INSURANCE INFORMATION

Primary Insurance

Insurance Company:__________________________

Insured's Name:______________________________

Relationship to Patient:__________________________

ID Number/Social Security #:___________________

Group Number:_______________________________

Insured's Date of Birth:__________________________

Secondary Insurance

Insurance Company:________________75___

Insured's Name:________________________

Relationship to Patient:____________________

ID Number/Social Security #:_______________

Group Number:___________________________

Insured's Date of Birth:_____________________

Copy of patient insurance card front and back faxed or emailed

AUTHORIZATION FOR TREATMENT, RELEASE OF INFORMATION, FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS

I authorize treatment of the above to pay all fees and charges for such treatment, promptly upon presentation of statement, unless prior credit arrangements have been agreed upon in writing. Charges shown by statement are agreed to be correct and reasonable unless protested in writing within thirty (30) days of the billing date. Although this office may assist me in filing and insurance claims, I understand that I am fully responsible for the balance and agree that payment will not be delayed because of any pending insurance claim. I authorize all insurance benefits, unless previously paid by myself, to be paid directly to this physician and also authorize the physician to release any information required in the processing of the insurance claim. Once payment is received from the insurance company, I will receive only one statement for the balance. It is expected that payment will be made within 10 days of receipt of first statement. If payment is not received, it will be considered past due and may be sent to collections.

PATIENTS WITH MEDICARE OR MEDICARE REPLACEMENT

I request that payment under the medical insurance program be made on my behalf to Robert Mahanti, M.D., for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Healthcare Financing

Administration and its agents any information needed to determine these benefits for the benefits payable for related services. I further permit a copy of this authorization to be used in place of the original. Refractions are a non-covered service of Medicare and are the patient's responsibility. I certify that I have given proper insurance information. If a referral is necessary with my insurance plan, it is my responsibility to obtain the necessary referral.

ALL PATIENTS MUST SIGN HERE:
Patient's Signature: ____________________________________

Date:_________________

Northern Arizona Eye Specialists

Patient's Name:____ Date:_____________

Please place a "C" next to any condition you currently suffer from, or a "P" for any condition you've had in the past. Please use the space next to the condition or the back of this sheet to elaborate if you think it will be helpful to us. Thank you!

Diabetes- If yes, for how long_________________
Type_________ Controlled_______________
Thyroid Disorder____________________________
Asthma / COPD / Chronic Bronchitis__________
Tuberculosis_______________________________
Migraines. With Visual Aura?_________________
Head or Spinal Injuries______________________
Multiple Sclerosis___________________________
Brain / Pituitary Tumor______________________
Other Neurological Condition_________________
Depression / Anxiety________________________
Cancer_____________________________________
Are you being treated for any other condition:
____
____

High Blood Pressure_________________________
Heart Attack? When?________________________
Stroke? When?_____________________________
Carotid Artery Disease_______________________
Other Heart Problems________________________
Kidney Disease_____________________________
Hepatitis__________________________________
AIDS / HIV_________________________________
Osteoarthritis______________________________
Rheumatoid Arthritis / Lupus / Gout__________
Other Psychiatric Disorder___________________
Any other Immune/Autoimmune Disorder:
____
____
____ _____________________________________

Women: If you are currently pregnant, what is your due date__________, or are you nursing ______

OCULAR HISTORY:

Contact Lens Wear: Soft / Hard / Gas Perm______
Power, if you know__________________________
Keratoconus or Corneal Disease_______________
Cataracts___________________________________
Eye Surgery- please explain when and type:
____
____
____

Macular Degeneration- Wet or Dry__________
Retina Disease ______________________________
Glaucoma- For how long?___________________
"Lazy Eye"__________________________________
RK / LASIK / PRK ___________________________
Injury-_____________________________________
____
____

PLEASE LIST THE DATE AND TYPE OF ANY OTHER SURGERY YOU'VE HAD (Appendix, Tonsils, etc):

____

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Northern Arizona Eye Specialists

Patient's Name:____ Date:____________

SOCIAL HISTORY:

Have you ever smoked tobacco____ Do you currently smoke?_____ Do you chew tobacco? ____
Do you drink alcohol? Yes / No If yes, how much and how frequently_______________________
Do you regularly use recreational drugs?____

MEDICATIONS:

PLEASE LIST ALL MEDICATIONS, PRESCRIPTION AND NON- PRESCRIPTION AS WELL AS ANY VITAMINS OR SUPPLEMENTS YOU CURRENTLY TAKE. INCLUDE DOSAGE AND FREQUENCY.

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ALLERGIES AND ADVERSE REACTIONS:

PLEASE LIST ANY MEDICATIONS, PRESCRIPTION AND NON- PRESCRIPTION THAT YOU'VE EVER HAD AN ADVERSE REACTION TO. PLEASE INCLUDE THE REACTION.

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FAMILY HISTORY: Please note the relation to the patient of the person with the condition:

(F) Father (M) Mother (S) Sister (B) Brother (GP) Grandparent (O) Other Family Member

_____ Glaucoma _____ Cataracts _____ Diabetes: Type:______

____ Macular Degeneration ____ "Lazy Eye" ____ Heart Disease
____ Retinitis Pigmentosa ____ Retinal Detachment
____ Other Eye Problems:____
____

____ ____
Patient or Guardian Signature Technician Signature