The Eye & Laser Center
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:_____

SPOUSE OR LEGAL GUARDIAN

Name:_____
Address:_____
City:_____
State:_____ Zip Code:_____
Phone: _____ Cell Phone:_____
Social Security #:_____
□ Single □ Married □ Male □ Female
Birth Date:_____

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 □

EMERGENCY CONTACT OR CARETAKER

Name:_____
Address:_____
Phone:_____

Name of Primary Care Physician: _____

Who may we thank for referring you to our office? _____

Would you like to learn more about LASIK Surgery? □Yes □No □Maybe

INSURANCE INFORMATION **Please complete if insurance cards NOT available**

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:_____
Insured's Name:_____
Relationship to Patient:_____
ID Number #:_____
Group Number:_____
Insured's Date of Birth:_____

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. A 40% fee will be assessed to any balance sent to a collection agency.

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:_____

The Eye and Laser Center / NAES Surgery Center
HEALTH QUESTIONNAIRE

Patient's Name: _____ Date of Birth: _____ Age: _____

Height: _____ Weight: _____ (*If applicable*) 1st Surgery Date: _____ 2nd Surgery Date: _____

Have you or a blood relative ever had a problem with anesthesia? ☐ Yes ☐ No

Have you or a blood relative ever had a problem with bleeding and / or clotting? ☐ Yes ☐ No
Describe that bleeding/clotting/anesthesia problem: _____

List any medications you are allergic to & reaction: _____

Are you currently pregnant? ☐ Yes ☐ No ☐ Unsure ☐ Post-Menopausal ☐ Hysterectomy
Date of Last Menstrual Cycle? _____

Are you sensitive to topical Iodine? ☐ Yes ☐ No *OR* Any type of tape? ☐ Yes ☐ No

Please check all that you have/had:

_____ High blood pressure	_____ Stroke	_____ Chronic cough
_____ Irregular heartbeats	_____ Seizure	_____ Hiatal Hernia
_____ Heart attack	_____ Head injury	_____ Blood transfusion
_____ Open heart surgery	_____ Loss of consciousness	_____ Bleeding problems
_____ Chest pain	_____ Thyroid Disorder	_____ Hepatitis
_____ Heart murmur	_____ Cigarette smoker	_____ Liver disease
_____ Pacemaker	_____ Chronic pulmonary disease	_____ AIDS/HIV positive
_____ Cardiac arrest	_____ Asthma	_____ Alcohol abuse
_____ Diabetes	_____ Emphysema / COPD	_____ Drug addiction
_____ Hypoglycemia	_____ Chronic bronchitis	_____ Kidney disease
_____ Chemotherapy / radiation	_____ Sleep apnea	_____ Blood Clots/DVT

What previous surgeries and /or hospitalization have you had? When? _____

_____

Please list all medications you take on a regular basis. Please include dose and frequency:

Medication	Dosage	Number of Times / Day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

If applicable: I attest there are: □ No Changes from my previous surgery ***OR*** □ Changes as follows:

_____

Patient's Signature: #1_____ Date:_____ #2: _____Date:_____

Physician Signature:#1_____ Date:_____ #2:_____ Date:_____