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? _____________________________

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 the 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:________________

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

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
_____ Irregular heartbeats
_____ Heart attack
_____ Open heart surgery
_____ Chest pain
_____ Heart murmur
_____ Pacemaker
_____ Cardiac arrest
_____ Diabetes
_____ Hypoglycemia
_____ Chemotherapy / radiation

_____ Stroke
_____ Seizure
_____ Head injury
_____ Loss of consciousness
_____ Thyroid Disorder
_____ Cigarette smoker
_____ Chronic pulmonary disease
_____ Asthma
_____ Emphysema / COPD
_____ Chronic bronchitis
_____ Sleep apnea

_____ Chronic cough
_____ Hiatal Hernia
_____ Blood transfusion
_____ Bleeding problems
_____ Hepatitis
_____ Liver disease
_____ AIDS/HIV positive
_____ Alcohol abuse
_____ Drug addiction
_____ Kidney disease
_____ 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:__________

Robert Mahanti, MD

OCULAR HISTORY:

Contact Lens Wear?: Yes No If so - Soft / Hard / Gas Perm - circle one
Power (if known): ____________________________________
Keratoconus or Corneal Disease?: Yes No
Cataracts?: Yes No
Cataract Surgery?: Yes No If so, when _________________________________
Macular Degeneration?: Yes No Wet or Dry? _________________________
Retina Disease?: ____
Glaucoma?: Yes No For how long? _________________________________
"Lazy Eye"?: Yes No
RK/LASIK/PRK?: Yes No When? _____________________________________
Eye Injury or other eye surgery?: ____
____

SOCIAL HISTORY:

Have you ever smoked tobacco? Yes No
Do you currently smoke? Yes No
Do you chew tobacco? Yes No
Do you drink alcohol? Yes No If yes, how frequently? ___________________
Do you regularly use recreational drugs? Yes No

EMPLOYMENT:
Occupation or Employer: ____
Number of hours on computer/electronic device? _______________________________
Number of hours performing "near" activities (reading, find handiwork, etc) ___________
Do you have a CDL? __________ Do you drive frequently at night? _________________

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
___ Macular Degeneration ___ "Lazy Eye" Type: _______________
___ Retinitis Pigmentosa ___ Retinal Detachment ___ Heart Disease
___ Other eye problems: ____
____

____________________________ ____________________________ ______________
Patient/guardian signature Technician signature Date