MIDWESTERN UNIVERSITY CLINIC

PATIENT REGISTRATION FORM

Please Print

Please check one: ☐ NEW PATIENT ☐ PATIENT UPDATE

PATIENT INFORMATION

Patient Name: ______________________________________
(Last) (First) (MI)

Gender: (circle) M F Date of Birth: ____________________

Marital Status: M D S W Last four (4) of SSN: ______

Address: ____

City, State, Zip: ____
Please check the box next to the best phone # to reach you during the day.

Home phone #: _______________________________________ ☐

Cell phone #: ____ ☐

Work phone #: ____ ☐

Email address: ____

PARENT/GUARDIAN (if patient is a minor)

1) Name: ____
(Last) (First) (M)

Gender: (circle) M F Date of Birth: __________________

Relationship to Patient: ________________________________

Cell Phone #: ____

2) Name: ____
(Last) (First) (M)

Gender: (circle) M F Date of Birth: __________________

Relationship to Patient: ________________________________

Cell Phone #: ____

Emergency Contact: ______________________________________ Relationship: ______________________________________

Phone: ____

How did you hear about us: _________________________________ Referred by: ____

The Federal Government requires we obtain the following information for reporting purposes only.
People will not be identified by the following information.

1. What is your RACE? **A.** White **B**. Asian **C**. African American **D**. American Indian/Alaskan Native **E**. Native Hawaiian **F.** Pacific Islander **G**. More than one race
2. What is your ETHNICITY? **A.** Hispanic/Latino **B**. Non-Hispanic/Non-Latino
3. What is your primary language? **A.** English **B**. Spanish **C**. American Sign Language **D.** Other

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Primary Insurance

Insurance Company: ____________________________________

ID #: ____

Group #: ____

Effective Date: ____

Policy Holder: ____

Policy Holder DOB: ______________________ Gender: M F

Relationship to Patient: __________________________________

Secondary Insurance

Insurance Company: ____________________________________

ID #: ____

Group #: ____

Effective Date: ____

Policy Holder: ____

Policy Holder DOB: ______________________ Gender: M F

Relationship to Patient: __________________________________

Primary Care Physician: _________________________________ Phone #: ____

Primary Pharmacy: _____________________________________ Phone #: ____

SIGNED: ____ DATE: ______________________________________

MIDWESTERN UNIVERSITY

PATIENT AUTHORIZATION, ASSIGNMENT, AND ACKNOWLEDGMENT

Patient's Name: ___________________________ Patient's Account Number:_________________________

1. **PRIVACY NOTICE**: ________ (Initial) Midwestern University's Notice of Privacy Practices provides information about how Midwestern University may use and disclose my protected health information. I have been offered a copy of Midwestern University's Notice of Privacy Practices and have (initial one): ________ **Accepted** the copy, or ________ **Declined** the copy.

2. **AUTHORIZATION TO RELEASE INFORMATION**: _______ (Initial) I authorize Midwestern University to furnish requested information from my medical record to: (1) any insurance company, third-party payor, governmental agency, or workers' compensation carrier for the purpose of obtaining payment, and (2) any representatives of local, state, or federal agencies in accordance with law. Such information may include information concerning communicable diseases. I authorize the release of information from or the review of my medical record for the purpose of conducting any medical audits, utilization reviews, or quality assurance reviews. I further authorize Midwestern University to release information from or copies of my medical record to my referring physician or to any other health care facility or provider to which I may be transferred or referred. For care and treatment that I have paid for out-of-pocket, I acknowledge that I may make a written request to limit disclosure of certain records, except as otherwise required by applicable law.

3. **ASSIGNMENT OF INSURANCE BENEFITS**: ______ (Initial) In consideration of services rendered, I hereby transfer and assign to Midwestern University and to the licensed physicians, groups, or individuals who perform services for my care and treatment at Midwestern University, all of my right, title, and interest in any payment for services described herein as provided in any health insurance or similar policy or employee benefit plan. I understand that I am responsible for providing to Midwestern University all insurance information at the time of admission to allow for verification. I hereby certify that the insurance information that I have provided Midwestern University is true and accurate as of the date of service and that I am responsible for keeping it updated at all times. I understand that regardless of my assignment of insurance benefits, I remain personally responsible for the total charges of the services rendered.

4. **MEDICARE ASSIGNMENT OF BENEFITS**: _______ (Initial) I certify that the information I provided in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the release of information concerning me and any information needed for filing a Medicare claim to the Centers for Medicare and Medicaid Services (Medicare) or its Medicare Administrative Contractors. I request that payment of authorized benefits be made on my behalf and I assign my benefits payable to the physician or organization submitting a claim to Medicare for me. I understand that regardless of my assignment of Medicare authorized benefits and any subsequent reimbursement by Medicare, I remain responsible for any remaining balance due to Midwestern University and I agree to pay Midwestern University the remaining balance.

5. **APPOINTMENT OF REPRESENTATIVE AND JUDICIAL REVIEW**: _______ (Initial) I hereby appoint Midwestern University or the Clinic Operations Administrator or other representative as my duly authorized representative and assignee ("Representative") during any (1) administrative claims process; (2) appeal or review process for a denied claim; or (3) State or Federal legal process, necessary to collect claims submitted on my behalf, but denied on my plan. I hereby authorize the Representative to take all necessary actions to resolve any disputed claim for reimbursement for services provided to me by Midwestern University, including the filing of all necessary appeals and complaints with the proper authorities and the release of all information related to the services. If my claim for benefits is administratively denied in whole or in part, I hereby assign all causes of action for judicial review and/or appeal to my designated Representative. (This means that Midwestern University will arbitrate your claim for you.)

PATIENT AUTHORIZATION, ASSIGNMENT, AND ACKNOWLEDGMENT

6. **PATIENT RECEIPT OF PAYMENT**: ______ (Initial) I agree to immediately sign over and send directly to Midwestern University any funds that I receive from my insurance company in connection with services provided to me at Midwestern University. This is a direct assignment of my rights and benefits under my medical policy/plan. I understand this payment will not exceed my indebtedness to Midwestern University, and I agree to pay, in a timely manner, any balance of charges over and above the payments made to Midwestern University pursuant to this assignment of benefits.

7. **COLLECTION EFFORTS**: ______ (Initial) I authorize the release of any information pertinent to payment for services rendered to me by Midwestern University to any insurance company, adjuster, or attorney involved in Midwestern University's efforts to collect payment for services provided to me.

8. **DUPLICATION**: I permit a copy of this authorization, assignment, and acknowledgement to be used in place of the original.

9. **INSTRUCTION AND RESEARCH**: Your medical records may be used for purposes related to education, instruction, and/or research. Your medical records will be used for these purposes only after de-identification or as otherwise authorized by, and pursuant to, applicable regulation and law.

10. **RESPONSIBILITY FOR COSTS**: I acknowledge and agree that irrespective of any insurance coverage or the reasons for electing not to have a claim submitted to insurance for coverage, I am personally and fully liable for any and all costs related to the services received. To the extent that I am choosing not to have insurance cover the costs of services received, I do so voluntarily and I further understand that doing so is not a condition of or for treatment.

11. **PRIOR EXPRESS CONSENT**: As a service to our clients, we provide a courtesy appointment reminder call and possibly other important calls that may be placed using a pre-recorded message. By providing your cell phone number, you consent to receiving such calls at this number. If you do not wish to receive these calls, please check the box that you wish to opt out ☐ and initial _________.

12. **NEW PATIENT BOOKLET**: I have been provided with a copy of the "New Patient Booklet." ☐ initial _______.

13. **E-MAILS**: Occasionally Midwestern sends out information to let patients know of events that may be of interest. These reminders are sent via e-mail. If you wish to opt out please check the box and initial ☐____________.

Patient Signature: ____

Patient Printed Name: ____

Patient Representative Signature (if applicable): _____________________

Patient Representative Name (if applicable): __________________________

Date: ___________________________________

Relationship of Representative To Patient (if applicable): ________________________

Witness Signature: ___________________________

Witness Name: ________________________________

MIDWESTERN UNIVERSITY MULTISPECIALTY CLINICS

NOTICE OF SUPERVISED STUDENT, INTERN OR RESIDENT HEALTHCARE PROVIDERS INVOLVED IN PATIENT CARE

Midwestern University Clinic is a multi-specialty outpatient medical clinic dedicated to providing high quality care to patient. Midwestern University Clinic is affiliated with Midwestern University, a University specializing in medical and health science education at its campuses located in Glendale, Arizona and Downers Grove, Illinois, with colleges of osteopathic medicine, pharmacy, health sciences, optometry, and dental medicine. It is our belief that Midwestern University Clinic's affiliation with Midwestern University allows our health care providers to keep up to date with the latest treatments, technology and medical innovations.

Midwestern University Clinic is also a resource for the training of students, interns and residents in various health professions. Specifically, Midwestern University Clinic affords students, interns and residents studying various health professions at the University with the opportunity to participate in the delivery of care to patients as part of their educational experience, under the supervision of experienced attending physicians. As a result, one or more of Midwestern University's students, interns or residents may be involved in your treatment.

Any student, intern or resident involved in your care will be supervised by a fully licensed physician or other licensed healthcare professional and in no case will you be seen exclusively by a student, intern or resident. Prior to the beginning of your treatment, any student, intern or resident involved in your care will be introduced and identified to you.

If you have any questions about the involvement of students, interns or residents in patient care at the Midwestern University Clinic, please contact your provider.

____

Patient/Guardian Signature Date

____

Print Patient Name Patient Acct#

07/31/19 rlm

Midwestern University Eye Institute
3450 Lacey Road
Downers Grove, IL 60515

PEDIATRIC QUESTIONNAIRE

Last, First, MI: ________________________________ DOB ___ /___ /______ Age _______

Reason for today's visit: ____

Medical History

Pediatrician / Practice Name: ____

City: ________________ Phone Number: _________________ Last medical exam: ___ /___ /_______

Medical conditions: ____

Allergies: ________________________________ Any surgeries: ____________________________

Medications (including prescription, eye drops, supplements, vitamins, over-the-counter):
____

Flu vaccine: YES / NO Date administered: ________________________

Last eye exam: ___ /___ /______ Doctor's name: ___________________________

Eye conditions: _______________________________ Glasses prescribed: YES / NO

Review of Systems

Do you have symptoms in the following areas:	Yes	No
Constitution (i.e. fatigue, fever, night sweats, etc.)		
Cardiovascular/vascular (i.e. Chest pressure/ discomfort, irregular heartbeat, etc.)		
Ear/Nose/Throat/Mouth (i.e. Hearing loss, etc.)		
Respiratory (i.e. cough, wheezing, etc.)		
Gastrointestinal (i.e. Constipation, diarrhea, vomiting, etc.)		
Genitourinary (i.e. Painful/difficult urination, blood in urine, etc.)		
Neurological (i.e. Dizziness, gait disturbance, headache, etc.)		
Psychiatric (i.e. Emotional changes, etc.)		
Endocrine (i.e. Heat/cold intolerance, excessive thirst/hunger/urination, etc.)		
Hematologic (Blood)/ Lymphatic (i.e. abnormal bleeding/bruising, etc.)		
Allergic/Immunologic (i.e. environmental/food allergies, etc.)		

Family History

Family History	Yes	No
Glaucoma		
Macular Degeneration		
Retinal disease		
Loss of vision/blindness		
Lazy eye/amblyopia		
High blood pressure/Hypertension		
Diabetes		
Other conditions		

Social History

Screen Time hrs/day	
Hobbies	

Developmental History

Is the child adopted/ in foster care? YES / NO When / For how long: ______________________

Length of pregnancy: _____________________ Birth weight: ______________________________

Any complications during pregnancy or birth? YES / NO
If yes, please explain____

Has the child met developmental milestones? YES / NO
If no, please explain ____

At what age did your child perform the following?

Crawling: _____________ Walking: _____________ Saying single words: _____________

Participating in any therapies (i.e. speech, behavioral, physical, occupational, or vision therapy) currently or in the past? YES / NO
If yes, what/when/ how often ____

Child undergone any of the following: (circle): Educational, Neurological, Psychological Testing

Any other information: ____

School Information

Grade: _____________ Any grades repeated: YES / NO If yes, what grade __________________

Any IEP/504 plan, if yes please specify ____

Other relevant academic information ____

Please answer the following questions:	YES	NO
Do your eyes feel tired when reading or doing close work?		
Do you have headaches while reading or doing close work?		
Do you have double vision while reading or doing close work?		
Do you notice words blurring or coming in and out of focus while reading or doing close work?		
Do you lose your place while reading or doing close work?		