IOANNIS P. GLAVAS, MD, PLLC 5 CAMBRIDGE CENTER, 8th FL, CAMBRIDGE, MA 02142 (617) 725-1921

PATIENT REGISTRATION

Mr. Ms.
Dr. Mrs. ____
(circle one) Last Name First Name Middle Name

☐ MALE ☐ FEMALE DATE OF BIRTH ____/____/______ AGE __________

OCCUPATION: ____________________ SOCIAL SECURITY # ________-_______-__________

PERMANENT ADDRESS:

____
Street City State Zip

LOCAL ADDRESS:

____
Street City State Zip

TELEPHONE:

____(_____)______________ (_____)______________ (_____)______________
Home Work Local

MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Partnered ☐ Unknown

For insurance purposes, marital status is required. If you do not wish to disclose marital status, please check 'Unknown'

PRIMARY CARE PHYSICIAN: ______________________ PHONE: (_____)__________

ADDRESS: ____

REFERRING PHYSICIAN: ______________________ PHONE: (_____)__________

ADDRESS: ____

INSURANCE INFORMATION

☐ No Medical Coverage

☐ Medical Coverage provided by:

Insurance Carrier: ______________________
Subscriber Name: ______________________
Subscriber Date of Birth: __________ Relationship to Patient: __________
Insurance ID Number: ______________________

To ensure accurate billing, please have your insurance card available at the time of your appointment. A copy will be retained in your medical record.

REFERRAL WAIVER

My insurance may require a referral/authorization. I am aware that I do not have a referral from my Primary Care Physician (PCP) for my office visit. I further understand that if I do not contact my PCP to obtain a referral, I will be financially responsible for any charges denied by insurance for lack of referral/authorization. I am responsible for contacting the billing department at (617)725-1921 to provide the referral number.

Signature of Patient: ______________________ Date: __________

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment below.

Signature of Patient: ______________________ Date: __________

IOANNIS P. GLAVAS, MD, PLLC --- 5 CAMBRIDGE CENTER, 8th FL, CAMBRIDGE, MA 02142 --- (617) 725-1921

MEDICAL HISTORY

Mr. Ms.
Dr. Mrs.____
(circle one) Last Name First Name Middle Name

☐ MALE ☐ FEMALE DATE OF BIRTH ____/____/____ AGE ______

Do you wear glasses? ☐ Yes ☐ No
If yes, for how long?______________

Do you wear contact lenses? ☐ Yes ☐ No
If yes, for how long?______________

Chief medical reason for this visit:

____

Brief history of this present illness:

____

____

General medical history (check all that apply):

☐ Anemia
☐ Blood Clots
☐ Convulsions
☐ Fainting Spells
☐ Hepatitis
☐ Kidney Disease
☐ Pink Eye
☐ Other: ______________________
☐ Arthritis
☐ Cancer: ____________
☐ Diabetes
☐ Headaches (Severe)
☐ Herpes
☐ Neck Problems
☐ Stroke Paralysis
☐ Asthma
☐ Cold Sores
☐ Dry Eyes
☐ Heart Problems:______________
☐ High Blood Pressure
☐ Lung Problems: ______________
☐ Skin Problems: ______________
☐ Back Problems
☐ HIV contact
☐ Excessive Bleeding

Current medications:

____

____

Family history of eye disease (specify family member):

☐ Cataracts ______________
☐ Keratoconus ______________
☐ Retina Disease ______________
☐ Glaucoma ______________
☐ Macular Degeneration ______________
☐ Other: ______________

Current eye medications:

____

____

Prior eye surgeries/dates:

____

____

Allergies:

☐ Latex ☐ Adhesive Tape ☐ Iodine

Medications: ____

Other: ____