

# Reingold Eye Center

## Patient Registration Sheet (Please Print)

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
(Circle one: Mr. Ms. Mrs. Miss)

Address: \_\_\_\_\_

\_\_\_\_\_ City State Zip

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date Of Birth: \_\_\_\_\_

E-Mail: \_\_\_\_\_

Sex: Male Female Marital Status: S M D W DP

Spouse / Parent Name: \_\_\_\_\_

Responsible Party: \_\_\_\_\_ Relationship: \_\_\_\_\_

Employed By: \_\_\_\_\_

Address: \_\_\_\_\_

Occupation: \_\_\_\_\_

Referred By: \_\_\_\_\_ Phone #: \_\_\_\_\_

Patient's Primary Care Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

\*\*\* In Case Of Emergency please contact: \_\_\_\_\_

Phone #: \_\_\_\_\_ Relationship: \_\_\_\_\_

Insurance: (Primary) \_\_\_\_\_

Secondary, if applicable: \_\_\_\_\_

I authorize the release of any medical information necessary to process this claim, and authorize the release of payment for medical benefits to my physician. I understand I am financially responsible to said doctor for all charges. We do not render services on the assumption that your charges will be paid by your insurance company.

I have been informed, and understand, that if my eyes are being dilated my vision will be blurred for approximately 4 hours and I may not be able to drive during this time.

1. Patients signature: \_\_\_\_\_ Date: \_\_\_\_\_
2. Patients signature: \_\_\_\_\_ Date: \_\_\_\_\_
3. Patients signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Medical History Questionnaire

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Date of last exam: \_\_\_\_\_

List any medications you currently take (Rx and over the counter) _____
Do you have any allergies to any medications?    Yes    No If Yes please list _____
List all major illnesses: (glaucoma, diabetes, high blood pressure, heart attack etc.) or injuries (concussions, etc.) _____
List any surgeries you have had (cataracts, appendectomy): _____

Do you currently have any problems in the following areas? If YES, please provide additional information.

	YES	NO	Details
Eyes (poor vision, eye pain, tearing, redness etc.)			
General / Constitutional (fever, heat stroke, weight loss, weight gain, unusually tired)			
Ears, Nose, Throat (hard of hearing, stuffy nose, ear ache, cough, dry mouth, etc.)			
Cardiovascular (high blood pressure, racing pulse, etc.)			
Respiratory (congestion, wheezing, short of breath, etc.)			
Gastrointestinal (upset stomach, diarrhea, constipation, hernia, ulcer, etc.)			
Genital, Kidney, Bladder (painful urination, frequent urination, impotence, yellow jaundice, etc.)			
Females: Are you pregnant? Nursing?			
Muscles, Bones, Joints (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
Skin (pimples, warts, growths, rash, etc.)			
Neurological (numbness, headache, seizures, paralysis, etc.)			
Psychiatric (anxiety, depression, insomnia)			
Endocrine (diabetes, hypothyroid, etc.)			
Blood / Lymph (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)			
Allergic / Immunologic (sneezing, swelling, redness, itching, hives, lupus, etc.)			

## Family History (Mother, Father, Grandparents, Sibling)

Has a member of your family had these diseases (circle one)?	Yes	No	Unknown
Blindness, Cataracts, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis Other heritable disease: _____			

## Social History

Does your vision limit any activities of daily living? (Driving, reading, sports, work, etc.)?    Yes    NO
Have you ever had a blood transfusion?    Yes    No
Do you drink alcohol?    Yes    No    If Yes, how much? _____
Do you smoke?    Yes    No    If Yes, how much? _____    How many years? _____

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## OFFICE FINANCIAL POLICY AND SERVICE CONTRACT

\_\_\_\_\_ 1. I understand that Warren J Reingold MD AMC will bill my insurance as a courtesy, but my patient portion (co-pays for office visits, deductible, and coinsurance for procedures) is my responsibility and due at the time of service. If your staff is unable to determine what my responsibility will be, I will be billed and my payment is due upon the receipt of the first invoice. An interest charge of 1.5% per month or 18% per year may also apply to delinquent balances. If your account is sent to an outside collection agency there will be a 30% fee added to your outstanding balance. This office policy is an effort to reduce costs related to our collection efforts so we can offer you more affordable healthcare overall.

\_\_\_\_\_ 2. I understand that if Warren J Reingold MD AMC is contracted with my insurance company, you will apply the contracted adjustment to my claims reducing my costs. If I have Medicare, you will file my secondary insurance. For both Medicare and other major insurances, I understand your staff will notify me of any services recommended for me that my insurance may not cover. I understand that these non-covered services that may be considered not medically necessary by my insurance are my responsibility and the contracted rate adjustment will not apply.

\_\_\_\_\_ 3. I authorize Warren J Reingold MD AMC to release any information to my insurance company, adjuster, or attorney involved in this case.

\_\_\_\_\_ 4. I have received a copy of the notice informing me of my privacy rights and understand that my health information will be used for treatment, billing, and office operation.

\_\_\_\_\_ 5. If my insurance fails to pay my claim in a timely manner, I authorize Warren J Reingold MD AMC to initiate a complaint to the insurance Commissioner for any reason on my behalf.

\_\_\_\_\_ 6. I authorize payment be made by my insurance company directly to Warren J Reingold MD AMC. If my current policy prohibits direct payment to Warren J Reingold MD AMC, I hereby instruct my insurance company to make out the check to me and mail it as follows 12139 Riverside Dr. Valley Village, CA 91607. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.**

\_\_\_\_\_ 7. I authorize Warren J Reingold MD AMC to deposit checks received on my account for services rendered if they are made out in my name.

\_\_\_\_\_ 8. My primary insurance company \_\_\_\_\_, is responsible for this bill. I may have a secondary benefits with another insurance company, but primary responsibility for my claim is with \_\_\_\_\_ insurance company. A photocopy of this financial agreement shall be considered as effective and valid as the original.

By signing below, I acknowledge that I've read and accept all terms of the above agreement. I also understand that I'm welcome and encouraged to express all concerns arising out of the financial aspects of my medical care.

\_\_\_\_\_  
Patient Name (Printed)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



## Office Policy

All co-payments are expected to be collected in full at the time of each visit.  
A \$25.00 additional fee will be charged if payment is not collected at time of service.

### Refraction and Contact Lens Prescriptions:

As most of you already know, refraction (prescription for glasses) and contact lens prescription, evaluations, fittings and supplies usually are not covered by your medical and/or vision insurance policies, and are not included as a part of a comprehensive eye examination.

Refraction, Contact lens fitting and evaluation Fees are as follows:

(contact lenses and supply fees are not included)

Refractions (prescription for glasses) Medical insurance cannot be billed for this service. Payment will be expected at time of visit	\$45.00
Contact lens evaluation and over-refraction (For patients who currently wear contact lenses) Please note: If you do not have a valid written prescription of your contact lenses, you will need a new contact lens fitting. (Contact lens containers are not acceptable) (By Law prescription is good for one year)	\$60.00
New contact lens fitting and training Daily wear and disposable soft contact lenses Please allow 1 hour (in addition to exam) (Prescription is good for one year)	\$125.00
Toric soft contact lens fitting and training Please allow 1 - 1½ hours (in addition to exam) (Prescription is good for one year)	\$150.00
Bifocal contact lens fitting	\$150.00
Hard and gas permeable contact lens fitting	\$200.00
Lasik 2 Hour Exam will be patient's responsibility if procedure does not take place within three months.	\$150.00
• Release of patient records to patient	\$25.00

Thank you

I understand and agree to the above.

\_\_\_\_\_  
Patient signature

\_\_\_\_\_  
Date

## Pharmacy Information



This information will be used to expedite any prescriptions you may need filled. Please complete this form in its entirety. All information is needed.

Patient Name: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_

Pharmacy Phone Number: \_\_\_\_\_

Pharmacy Address: \_\_\_\_\_  
\_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

WARREN J. REINGOLD, M.D.  
A Medical Corporation  
Eye Physician & Surgeon

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LIFESTYLE QUESTIONNAIRE

Name: \_\_\_\_\_ Date Completed: \_\_\_\_\_

1. What hobbies or activities do you enjoy? Check all that apply.

Golf	Running	Gardening
Tennis	Reading	Cooking
Water Sports	Internet	Other _____

2. Are you experiencing any difficulties with your glasses and/or contact lenses with the above mentioned activities? Check all that apply.

Glare	Inconsistent Vision
Fogging	Constant Adjustment
Other: _____	

3. Are your lenses scratched or damaged from regular use? Yes No

4. Do you spend more than 2 hours a day viewing a computer screen? Yes No

5. Do you consider yourself sensitive to sunlight? Yes No

6. Do you spend more than 1 hour a day in the sun? Yes No

7. Would thinner/lighter lenses appeal to you? Yes No

8. Do your current glasses cause indentions on your nose do to weight? Yes No

9. Which statement best describes you?

I lead an active lifestyle, which includes exercise and recreation.

I enjoy being outside as much as possible.

I am allergic to nickel products

I try to keep up with the latest fashion trends.

I use a computer (either at work or at home) and spend 2 or more hours at a screen

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Reviewed by: \_\_\_\_\_ (Technician/Staff Member)

# Acknowledge of Receipt of Notice of Privacy Practices

Warren J Reingold, M.D., AMC  
12139 Riverside Dr  
Valley Village, CA 97607

Nathan Spengel / Cindy Allen – Privacy Officers (818) 763-3937

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy at each appointment.

I would like to receive a copy of any amended Notice of Privacy Practices by e-mail

at: \_\_\_\_\_.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

If not signed by the patient, please indicate:

Relationship:

parent or guardian of minor patient

guardian or conservator of an incompetent patient

beneficiary or personal representative of deceased patient

Name of Patient: \_\_\_\_\_