LYLE R. TESKA, MD PA

FIRST NAME:_____ MI:_____ LAST NAME:_____

ADDRESS:_____ CITY:_____ ST:_____ ZIP:_____

DATE OF BIRTH:_____ AGE:_____ SEX:_____ MARITAL STATUS:_____ SS#_____

TELEPHONE:_____

HAVE YOU BEEN SEEN HERE BEFORE, UNDER WHAT NAME?_____

PERMANENT ADDRESS:_____

TELEPHONE:_____

EMPLOYER INFORMATION:

EMPLOYERS NAME:_____ ADDRESS:_____

CITY:_____ ST:_____ ZIP:_____ TELEPHONE:_____ OCCUPATION:_____

RESPONSIBLE PARTY/PARENT/SPOUSE:

NAME:_____ RELATIONSHIP TO PT:_____

ADDRESS:_____ CITY:_____ ST:_____ ZIP:_____ OCCUPATION:_____

EMPLOYER_____ ADDRESS:_____ CITY:_____ ST:_____ ZIP:_____

SS#_____ DOB:_____ WORK PHONE: _____

REFERRED BY: _____

FAMILY/PCP PHYSICIAN: _____ PHONE: _____

INSURANCE INFORMATION:

INSURANCE COMPANY _____

POLICY # _____ GROUP#: _____

NAME OF POLICYHOLDER _____

DATE OF BIRTH: _____ POLICYHOLDER SS# _____

SUPPLEMENTAL INSURANCE INFORMATION:

INSURANCE COMPANY _____

POLICY # _____ GROUP#: _____

NAME OF POLICYHOLDER _____

DATE OF BIRTH: _____ POLICYHOLDER SS# _____

PLEASE READ AND SIGN

I HEREBY AUTHORIZE LYLE R. TESKA, MD AND STAFF TO PERFORM PROCEDURES NECESSARY TO ASSESS AND DIAGNOSE MY CONDITION PROPERLY, AND SUCH TREATMENTS AS MAY BE PRESCRIBED BY MY ATTENDING PHYSICIAN DURING ANY AND ALL VISITS TO LYLE R. TESKA, MD. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES ARISING FROM SERVICES RENDERED TO ME BY LYLE R. TESKA, MD.

SIGNATURE: X _____

RELEASE OF INFORMATION

I hereby authorize Lyle R. Teska, MD to release any information concerning my care for purpose of claims to Federal, State, City, or Town Governmental Agencies, third party payors of all categories, doctors, and hospitals.

I permit a copy of this authorization to be used in place of the original.

Signature of Patient _____ **Date:** _____
OR
Signature of Other
Responsible Person _____ **Date:** _____

ASSIGNMENT OF BENEFITS

I hereby agree to pay the established charges for services and all other charges incurred as a patient of Lyle R. Teska, MD PA.

I further hereby authorize payment directly to Lyle R. Teska, MD PA the group hospital benefits or insurance benefits, including Medicare, herein specified and otherwise payable to me, but not to exceed the regular charges for this period of admission. I understand that I am financially responsible to Lyle R. Teska, MD PA for charges not covered by this authorization.

I will cooperate in seeking, collecting, and paying to Lyle R. Teska, MD PA, any and all insurance proceeds. If the insurance proceeds cannot be paid directly to Lyle R. Teska, MD PA, I agree to collect payment and pay to Lyle R. Teska, MD PA within seven (7) days of receipt.

Signature of Patient _____ **Date:** _____
OR
Signature of Other
Responsible Person _____ **Date:** _____

PATIENT HISTORY RECORD

PATIENT'S NAME: _____ ACCOUNT#_____

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR MEDICAL HISTORY:

1. ARE YOU BEING TREATED FOR ANY MEDICAL CONDITIONS? (e.g., diabetes, high blood pressure, arthritis, etc)
   YES NO If yes please :_____

   _____

2. HAVE YOU EVER HAD ANY EYE DISEASE? (e.g., glaucoma, cataract, wandering or "lazy eye" retinal detachment)
   YES NO If yes please list:_____

3. HAVE YOU EVER HAD ANY SURGERY?
   YES NO If yes, please provide date and reason:_____

   _____

4. DO YOU TAKE ANY MEDICATIONS?
   YES NO If yes, please list:_____

   _____

5. DO YOU USE ANY EYE MEDICATIONS?
   YES NO If yes, please list;_____

   _____

6. DO YOU HAVE ANY DRUG OR FOOD ALLERGIES?
   YES NO If yes, please list;_____

   _____

Do you currently have any of the following problems:			If yes, please explain:
Chronic fever, unexpected weight loss/gain, fatigue	YES	NO	_____
Ear/nose throat problems (e.g., hearing loss, sinus problems, sore throat)	YES	NO	_____
Heart problems (e.g., chest pain, irregular heart beat)	YES	NO	_____
Respiratory problems (e.g., shortness of breath, wheezing, coughing)	YES	NO	_____
Gastrointestinal problems (e.g., heartburn, abdominal pain, diarrhea, vomiting)	YES	NO	_____
Urinary problems (e.g., pain or discomfort, blood in urine)	YES	NO	_____
Skin problems (e.g., rashes, excessive dryness)	YES	NO	_____
Musculoskeletal problems (e.g., muscle aches, joint pain, swollen joints)	YES	NO	_____
Neurological problems (e.g., numbness, weakness, headaches, paralysis)	YES	NO	_____
Psychiatric problems (e.g., depression, anxiety)	YES	NO	_____

7. DO ANY MEDICAL OR EYE DISEASES RUN IN YOUR FAMILY? (e.g., diabetes high blood pressure, cancer, glaucoma, macular degeneration)
   YES NO If yes, please explain:_____
8. Do you smoke?
   YES NO If yes, how much? _____
9. Do you drink alcohol?
   YES NO If yes, how much? _____
10. If employed, how many hours per week do you work? _____