PATIENT REGISTRATION

Referred by:_____ **Primary Care Dr.**_____

Patient Name._____ Today's Date_____
Last First Middle

Home Address_____

City_____State_____ Zip Code_____

Home Phone_____Cell Phone_____

E-mail address_____ Marital Status Single Married Divorced Widowed

Social Security Number_____Date of Birth_____ Age _____ Gender M F

Employer/Parent's Employer_____Occupation_____

Work Phone :_____City_____State_____Zip Code_____

Spouse name (Parent name if minor)_____Spouse/Parent Work Phone_____

Person to notify in case of emergency (other than spouse)_____

Phone number (s)_____Relationship_____

Primary Insurance Company		
ID#	Group #	Effective Date
Subscriber Name		**Relationship to Patient**
Social Security Number	Date of Birth	Employer

Secondary Insurance Company		
ID#	Group #	Effective Date
Subscriber Name		**Relationship to Patient**
Social Security Number	Date of Birth	Employer

I certify that I (or my dependent) have insurance coverage as stated above and agree to have insurance payments made directly to Northern Wyoming Ophthalmology, P.C.to be applied to my account for services rendered. I understand that I am financially responsible for all charges incurred in the event that my insurance denies payment. I am aware there may be additional collection and/or attorney's fees if my account is referred for collection. For patients covered by Medicare the patient will be responsible for 20% of the Medicare allowable charges plus any deductibles, coinsurance and uncovered charges that apply.
I also understand that by giving my cell phone number, I am giving Northern Wyoming Ophthalmology, PC and/or assignee permission to call that phone number.

_____ _____
PATIENT'S SIGNATURE DATE

BARRY P. WELCH, M.D.
MEDICAL HEALTH QUESTIONNAIRE

Name:_____ Date:_____
Primary
Physician:_____Pharmacy:_____

PLEASE CHECK ALL THAT APPLY TO YOU

Past eye problems:

_____cataracts
_____double vision/prism in glasses
_____glaucoma
_____infections
_____injuries or trauma
_____macular degeneration
_____muscle imbalance
_____crossed or lazy eye
_____retinal problems
_____other

Please explain all checks: _____

_____

Glasses
Wear: NOW PREVIOUSLY

Contacts
Wear: NOW PREVIOUSLY

Family eye history: Has any **blood relative** been diagnosed with the following:

_____cataracts
_____diabetes
_____glaucoma
_____blindness
_____retinal problems
_____macular degeneration
_____muscle imbalance/crossed/lazy eye
_____other

Please explain all checks: _____

_____

PLEASE CHECK ALL THAT APPLY TO YOU

_____allergies/hay fever
_____arthritis or joint problems
_____bleeding tendency/easy bruising
_____cancer
_____diabetes
_____ear/nose/throat/mouth disorders
_____headaches/sinus tension or hormonal
_____heart problems
_____hepatitis (jaundice)
_____high blood pressure
_____HIV infection/AIDS
_____lung problems/asthma/emphysema
_____lymphatic abnormalities
_____migraines
_____neurological problems/Parkinson's
_____pregnant
_____psychiatric problems
_____restless leg
_____sinus problems
_____skin disorders/rashes
_____sleep apnea
_____stomach problems/ulcer
_____strokes
_____thyroid disease
_____tuberculosis
_____urinary, bladder or prostate
_____using oral contraceptives

Any additional information_____

**********PLEASE SEE OTHER SIDE**********

All Prior Surgeries:

_____appendectomy
_____gall bladder
_____heart surgery
_____other

_____ prostate surgery
_____ tonsillectomy
_____hysterectomy

Explain: _____
_____

Past Eye Surgeries: **Date:**

_____

Occupation: _____ **Hours per day on digital equipment:**____
(cell phone, tablet, computer)

HOBBIES: Fishing Hunting Reading Sewing Hiking OTHER: _____

Alcohol consumption Yes No Amount: _____
Current Smoker: Yes No Amount: _____
Date quit: _____

Current Medications:

_____
_____
_____
_____
_____
_____
_____
_____

Eye Medications:

_____
_____
_____

Do you use a C-PAP Machine?
Yes No

Allergies to any medication: Yes No _____
_____

Have you ever taken:			
	Flomax (Tamsulosin)	**Yes**	**No**
	Hytrin (Terazosin)	**Yes**	**No**
	Cardura (Doxazosin)	**Yes**	**No**
	Saw Palmetto	**Yes**	**No**
	Rapaflow	**Yes**	**No**

Previous eye doctor:_____**Addres:**_____
DATE OF LAST EYE EXAM: _____

Tell Us About You

Understanding your lifestyle and the activities you enjoy can help us recommend the kind of cataract surgery that will provide you with clearer vision and less dependence on glasses.

Name _____

What is (or was) your occupation? _____

Please circle the following activities you do on a regular basis:

Distance Vision

- Driving—daytime
- Driving—nighttime
- Golfing/Other sports
- Watching movies/Going to theater
- Viewing scenery/Taking photographs
- Other: _____

Intermediate Vision

- Seeing car dashboard
- Using computer
- Using tablet
- Shopping
- Playing cards
- Other: _____

Near Vision

- Reading books/newspapers
- Doing crossword puzzles
- Using cell phone
- Sewing/Needlepointing
- Applying makeup
- Other: _____

Are you having any difficulty with the following with your current vision?

☐ Bright daylight ☐ Nighttime streetlights/headlights ☐ Reading

Tell Us About You (cont.)

Please place an "X" on each continuum where it best describes how you feel about the following:

Correction of near vision:
(e.g., reading, use of phone)

I want to wear glasses — I don't want to wear glasses

Correction of intermediate vision:
(e.g., using a tablet/computer)

I want to wear glasses — I don't want to wear glasses

Correction of distance vision:
(e.g., driving, watching television)

I want to wear glasses — I don't want to wear glasses

Your doctor will discuss the advantages and disadvantages of the various options for cataract surgery. Please indicate how knowledgeable you are about your cataract surgery options:

☐ Not knowledgeable ☐ Somewhat knowledgeable ☐ Knowledgeable

Which of the following best describes your personality type?

☐ Easygoing ☐ Flexible ☐ Organized/Planner ☐ Perfectionist

Your signature _____

Northern Wyoming Ophthalmology, P.C.
Barry P. Welch M.D.
"Eye M.D."
Board Certified
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Cody, WY 82414
(307) 587-5538 • welcheyemd.com • Fax (307) 587-4896

Dear

Enclosed please find our patient information sheet, medical questionnaire, and HIPPA form that we will need completed for your upcoming appointment with Dr. Barry P. Welch, Please note that the Medical History (green) sheet has two side. **PLEASE RETURN THESE FORMS TO OUR OFFICE IN THE ENCLOSED STAMPED ENVELOPE.**

Your appointment will last between **1 ½ to 3 hours**. Please note that your eyes will be dilated. If you are not comfortable driving with dilated eyes, please arrange to have a driver accompany you to your appointment.

If your appointment is for a cataract evaluation and you wear contacts, please note:

> Soft contact lens wearer **must be out** of your contact lenses for a minimum of **3 weeks** prior to your exam.
>
> RGP contact lenses wearer, **must be out** of your contact lenses for a minimum **of 4-6 weeks** prior to your exam.

Please review the enclosed information from ALCON regarding the lens implant options and check out **MYCATARACTS.COM** for more detailed information.

We ask that your bring your insurance cards and driver's license with you to your appointment so we may scan them into our medical records.

Our office is in the Cathcart Health Center at 424 Yellowstone Ave., Suite 110. If you have any questions or unable to keep your appointment, please contact us at (307) 587-5538.

Thank you.

Enclosures