



CHICAGOLAND  
EYE CONSULTANTS

# PATIENT REGISTRATION FORM

PHONE: 773.775.9755 | FAX: 773.775.4306 | CHICAGO-EYE.COM

**Name:** \_\_\_\_\_ **Sex:**  M  F **Age:** \_\_\_\_\_ **Birth Date:** \_\_\_\_\_ **Marital Status:** \_\_\_\_\_  
**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **ZIP:** \_\_\_\_\_ **Preferred Language:** \_\_\_\_\_  
**Email:** \_\_\_\_\_ **Phone home:** \_\_\_\_\_ **work:** \_\_\_\_\_ **cell:** \_\_\_\_\_  
**Race/Ethnicity:**  Hispanic  American Indian or Alaskan Native  Asian  Black or African American  Pacific Islander  Caucasian  Unknown  
**Patient SSN (optional):** \_\_\_\_\_ **Referred by:**  Friend/Family  Dr. \_\_\_\_\_  Internet  Other  
**Family Doctor:** \_\_\_\_\_ **Phone:** \_\_\_\_\_  
**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **ZIP:** \_\_\_\_\_  
**Parent Name (if minor):** \_\_\_\_\_ **Parent SSN:** \_\_\_\_\_  
**Bill to:** \_\_\_\_\_ **Relationship to patient:** \_\_\_\_\_  
**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **ZIP:** \_\_\_\_\_  
**Check one:**  HMO  PPO  Workman's Comp  Private Insurance  Patient Pay  Medicare  
**Primary Insurance:** \_\_\_\_\_ **Subscriber's Name:** \_\_\_\_\_ **Relationship to Patient:** \_\_\_\_\_  
**Policy #:** \_\_\_\_\_ **Subscriber's ID#:** \_\_\_\_\_ **Subscribers D.O.B.:** / /  
**Secondary Insurance:** \_\_\_\_\_ **Subscriber's Name:** \_\_\_\_\_ **Relationship to Patient:** \_\_\_\_\_  
**Policy #:** \_\_\_\_\_ **Subscriber's ID#:** \_\_\_\_\_ **Subscribers D.O.B.:** / /  
**Employment:**  Occupation  Retired  Student  
**Employer:** \_\_\_\_\_ **Supervisor Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Ext:** \_\_\_\_\_  
**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **ZIP:** \_\_\_\_\_  
**Emergency Contact:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

How did you hear about our clinic?:

## MEDICAL HISTORY

CONDITION	YOU		PARENT/SIBLING	
	Yes	No	Yes	No
Prostate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes (onset: _____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease / Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma / Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin / Blood Thinner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Currently Pregnant / Breast Feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Smoke / Drink	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Communicable Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer / Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HIV / AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Difficulties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Renal Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Renal Dialysis Frequency:				
Other Respiratory Dx:				

## OCULAR MEDICAL HISTORY

Glaucoma (onset: _____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lazy Eye / Eye Turn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Night Vision Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eyeglasses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Contact Lenses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Refractive Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## ADDITIONAL INFORMATION

Major Surgeries:

Ocular Surgeries:

Medications:

Allergies:

Your Pharmacy:

Address

City

State

ZIP

Phone

How interested are you in having any non-surgical cosmetic treatment, such as Latisse, Botox or Juvederm?  Very Interested  Somewhat Interested  Not Interested

**Preferred Contact Method:**  Home  Work  Cell  Email

I believe that all the information is true and complete to the best of my knowledge and I give CEC permission to view my medication history:

**Patient (or parent) signature:** \_\_\_\_\_

Medical History Updated (for completion by office personnel only)

Date: \_\_\_\_\_ Initials: \_\_\_\_\_ | Date: \_\_\_\_\_ Initials: \_\_\_\_\_ | Date: \_\_\_\_\_ Initials: \_\_\_\_\_



JASMEET S. DHALIWAL, M.D.  
Comprehensive Ophthalmology  
Cataract Surgery  
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2371 Bowes Road, Suite 400  
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## Our Financial Policy

Thank you for choosing us as your eye care provider. We are committed to providing you with the highest quality of ophthalmologic care. Payment for the medical services rendered is an integral part of the financial support of our Practice. We require that you read and sign this form prior to any treatment.

**Medicare and Commercial Insurance Patients:** You must bring your insurance identification card on the day of your examination and present this card to the receptionist at the time of registration. **You are responsible for any co-payments, co-insurance and/or annual deductibles at the time of service.** As a courtesy, we will file with your supplemental insurance. In the event you do not have additional insurance, you will be responsible for the total balance due.

**HMO Patients:** All HMO patients **MUST** have a written referral from their primary care physician on the day of the examination. Please present the referral to our receptionist, at the time of registration. **It is your sole responsibility to obtain any and all referrals.** If you do not have your referral, your appointment will be rescheduled or you will be required to make full payment on the day of your examination.

**Worker's Compensation:** We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. **If your claim is denied, you will be responsible for payment in full.**

**Uninsured Patients:** Full payment is due at the time of service.

**Credit Card on File:** For your security and protection, Chicagoland Eye Consultants stores your encrypted and tokenized credit card data in an off-site, secure vault that exceeds all HIPAA and PCI Data Security Standards.

I authorize Chicagoland Eye Consultants to automatically debit the card on file for any patient responsibility, including standard co-pays, remaining balance, payment plans and no-show fees. I understand that I can update my card information on file at any time by contacting our office directly. In fact, it is my responsibility to notify Chicagoland Eye Consultants of any updates or changes to the credit card on file associated with this agreement as soon as possible.

### **Non-Payment**

Failure to pay will result in your account being referred to a collection agency, which will affect your credit. NSF checks will result in a \$35.00 returned check fee.

**Eye Refractions:** Most insurance companies do not pay for eye refractions. This test is necessary to determine if an eyeglass prescription will improve your ability to see.

\*I am aware that the charge for refraction is **\$35.00** and is payable on the day of my examination. I will receive a prescription card with my current glass prescription.

\*This test may be required by the doctor for diagnostic purposes, and in that case, you will not be charged for this test. You will not receive a prescription card for eyeglasses.

- **A 50% deposit is required on all contact lens and eyeglass orders. The remaining 50% balance is required at the time of pick-up.** Glasses and contacts purchases are **NON-REFUNDABLE**, but we will make every effort to ensure your satisfaction.

For your convenience, we accept cash, checks, Visa, MasterCard and Discover cards.

**Authorization:** I hereby authorize the release of any medical information necessary to process my insurance and authorize payment directly to Chicagoland Eye Consultants, S.C. dba Advanced Vision Specialists. I understand that I am financially responsible for charges not covered by my insurance and any balance will be paid by me upon receipt of the bill.

**There is a \$1.50 service fee for any statement printed after the 2<sup>nd</sup> request with no payment.**

**A service charge will be added for all accounts released for collection.**

\_\_\_\_\_  
(Signature of Patient or Responsible Party)

\_\_\_\_\_  
(Date)

TURN OVER PLEASE

\_\_\_\_\_  
PRINT Patient Name

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Medicare Identification Number

**1. MEDICARE**

I request that payment of authorized Medicare benefits be made on my behalf to Chicagoland Eye Consultants, S.C. dba Advanced Vision Specialists. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated, my signature authorizes releasing the information to the insurer or agency shown.

Chicagoland Eye Consultants, S.C. dba Advanced Vision Specialists accepts the allowed charge determination of the Medicare carrier as the full charge and I am responsible only for the deductible, co-insurance and non-covered services.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

**2. Secondary Insurance or other Insurance if not covered by Medicare**

I hereby authorize payment of my medical and surgical insurance benefits to Chicagoland Eye Consultants, S.C. dba Advanced Vision Specialists. I understand I am financially responsible for any charges whether or not paid by said insurance. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Chicagoland Eye Consultants, S.C. dba Advanced Vision Specialists. I authorize Chicagoland Eye Consultants, S.C. dba Advanced Vision Specialists to release any information required to process any and all claims for reimbursement on my behalf. A copy of this authorization may be used in place of the original.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date



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Dear Patient:

We are pleased to inform you that our office can provide you with one of the most thorough eye exams available. In order for us to thoroughly view the retina (the tissue that lines the inside of the eye) and other internal structures, we may need to dilate your eyes.

Dilation consists of placing drops in your eyes which will enlarge your pupils (the black circle in the center of the colored part of your eye). Dilation usually occurs within 15 minutes, after the drops are instilled. Due to the widening of the pupil, dilation will affect the comfort and ability of many patients when reading and may also cause light sensitivity. If possible, someone should accompany you to our office to drive you home, as dilation can impair your ability to drive. If that is not possible, you should use caution when driving or engaging in other hazardous activities, while your pupils are dilated. Disposable sun shades will be given to you after dilation, to protect your eyes in bright illumination, if you have not brought your own sunglasses. If you did not receive sun shades before you leave, please ask our Reception Staff for a pair.

We wholeheartedly recommend dilation, especially if you or a family member has a history of diabetes, retinal disease, flashes or floaters, glaucoma, cataracts, macular degeneration, a moderate or high degree of nearsightedness, or if you have not had your eyes dilated within the past year or two. In some cases, dilation may be the only effective way of detecting diseases of the retina and other internal structures of the eye.

Sincerely,

Jasmeet Dhaliwal, M.D.

I have read and understand the importance of dilation and that it would be in my best interest for evaluating the health of my eyes.

I hereby give consent to dilation:

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

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

I hereby **DO NOT** give consent to dilation: I understand the importance of dilation and that it would be in my best interest for evaluating the health of my eyes, however, at this time, I decline to be dilated.

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

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



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## PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With your consent, Chicagoland Eye Consultants, S.C. dba Advanced Vision Specialists may use and disclose protected health information about you to carry out treatment, payment and health care operations. Our *Notice of Privacy Practices* provides more detailed information about such uses and disclosures. You have a legal right to review our Notice of Privacy Practices prior to signing this consent, and we encourage you to read it in full.

As part of your healthcare, Chicagoland Eye Consultants, S.C. dba Advanced Vision Specialists originates and maintains health records describing your health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

The information we collect serves as a basis for planning your care and treatment; a means of communication among the many healthcare professionals who contribute to your care; a source of information for applying your diagnosis and surgical information for billing purposes; a means by which a third-party payer can verify that services billed were actually provided; and a tool for routine healthcare operations such as assessing quality care and reviewing the competence of your healthcare professionals.

With your consent, Chicagoland Eye Consultants, S.C. dba Advanced Vision Specialists may mail or call your home or office and leave a message in reference to information that assists us in carrying out treatment, payment and health operations, such as appointment reminders, insurance and billing issues and any call pertaining to your clinical care.

By signing this form, you are consenting to our use and disclosure of your protected health information for the purposes of treatment, payment or healthcare operations. This consent may be revoked in writing, except to the extent that we may have already made disclosures in reliance upon your prior consent.

**You may release information to:** \_\_\_\_\_

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

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

**If you are not the patient, please specify your relationship:** \_\_\_\_\_



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### NEW PATIENT INFORMATION

CREDIT/DEBIT CARD ON FILE: for your security and protection, Chicagoland Eye Consultants stores your encrypted and tokenized credit card information in an off-site, secure vault that exceeds all HIPAA and PCI Data Security Standards.

I authorize Chicagoland Eye Consultants to automatically debit the card on file for any patient responsibility, including standard co-pays, remaining balance, payment plans and no-show fees. I understand that I can update my card information on file at any time by contacting our office directly. In fact, it is my responsibility to notify Chicagoland Eye Consultants of any updates or changes to the credit card on file associated with this agreement as soon as possible.

- Chicagoland Eye Consultants will bill your insurance first.
- If there is a remaining balance on your account, your credit card/debit card will be charged the full remaining balance amount 10 days after your insurance processes your claim.
- If, **HOWEVER**, you do not want us to charge your credit card and would rather pay with another form of payment. Please contact our billing office at (773) 775-9755 within 10 days of receiving your statement to avoid credit card charges.

---

Patient Name

---

Date

---

Patient Signature

***Chicagoland Eye Consultants does not keep photos of credit or debit cards in electronic medical records, please hand your card to the front desk staff to enter data and they will hand the card back to you.***



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## ACKNOWLEDGEMENT OF SELF-PAY STATUS

Dear Patient,

You are being provided this letter of acknowledgment because you have requested that your doctor visit be coded as “self-pay” and that you receive a “self-pay discount”. A self-pay discount is offered to [patients who elect to pay for the service in full in the date of service and who will not be submitted the claim to an insurance carrier. You have requested that this service be coded as self-pay because (initial one):

\_\_\_\_\_ You have no health insurance

\_\_\_\_\_ You have health insurance but you do not want your insurance billed and instead want to pay out of pocket

\_\_\_\_\_ Other (please explain): \_\_\_\_\_

We want you to know what to expect so that you can make an informed decision. In order to accomplish this, by signing below you agree to the following:

- All fees for the self-pay service must be PAID UP FRONT on the date of service.
- The upfront self-pay amount covers only what the appointment is initially made for.
- You are financially responsible for any additional fees incurred during your exam, such as: Refraction & dilation fee, additional testing which may or may not include Visual fields, DAF, OCT, Fundus and ERG.

By my signature below, I acknowledge that I have read and understand the above and have been given the opportunity to ask questions. I confirm that I am the patient, or the patient’s duly authorized representative.

Patient or Representative Signature \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

If signed by someone other than the patient, please specify relationship to the patient: \_\_\_\_\_

Interpreter Signature \_\_\_\_\_ ID# \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_





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DATE: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

PATIENT DATE OF BIRTH: \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

\_\_\_\_\_ OPT IN FOR CONSTANT CONTACT EMAIL (QUARTERLY UPDATES)

\_\_\_\_\_ OPT IN FOR OPTICAL SALES (FRAMES, CONTACT LENS, ACCESSORIES)

\_\_\_\_\_ OPT IN FOR PERSONAL MEDICAL RECORD INFORMATION ONLY

\_\_\_\_\_ OPT OUT COMPLETELY

\_\_\_\_\_ DO NOT HAVE AN EMAIL

OTHER REASON \_\_\_\_\_



Date:

# PATIENT HEARING QUESTIONNAIRE

Please bring this completed form with you when you check in.

***The number of Americans with hearing loss has doubled over the past 30 years.\****

\*American Speech-Language-Hearing-Association

<b>Name</b> (Last, First, M.I.):	<input type="checkbox"/> M <input type="checkbox"/> F	<b>DOB:</b>
<b>Phone:</b>	What is the best time to call? <input type="checkbox"/> AM <input type="checkbox"/> PM	

## HEARING & COMMUNICATION SYMPTOMS

1. Do you ever experience feelings of dizziness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Do you have ringing or other noises (tinnitus) in your ears?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Do others complain that you watch television with the volume too high?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Do you frequently have to ask others to repeat themselves?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Do you have difficulty following conversations in groups or noisy situations?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Do you have to sit up in front in meetings in order to understand the speaker?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Do you have difficulty understanding women's or children's voices?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. Do you have trouble knowing from where sounds come?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9. Do you have trouble understanding when someone talks to you from another room?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
10. Do you have trouble understanding someone when they are not looking directly at you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
11. Do others tell you that you don't seem to be paying attention to them?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
12. Does it often seem like others are mumbling when they talk to you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
13. Do you avoid social situations because you cannot understand what people are saying?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
14. Do you have diabetes?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If you circled three or more "yes" answers above, you may be experiencing symptoms of hearing loss.

***Many people put off hearing exams simply because they are unaware that treatment of hearing loss can greatly improve their quality of life. Did you know that the days of bulky and uncomfortable hearing aids are a thing of the past? Our new designs are virtually invisible and so comfortable that you may even forget that you are wearing one!***

Our practice now includes a full hearing evaluation as part of the total care package that we offer to our valued patients.

To receive your complete hearing evaluation, please check this box

FOR OFFICE USE ONLY: Location (check one):