RAYMOND T. PEKALA, M.D.

PATIENT REGISTRATION

Last Name: _____ Date: _____

First Name: _____ MI: ____

Address: _____

City/State: _____ Zip Code: _____

SEX: M F

Marital Status:
Single Married Divorced Widowed Separated

Social Security Number: _____

Date of Birth: _____

Phone Numbers
Home: _____
Work: _____
Cell: _____

E mail: _____

Parent/Guardian/Emergency Contact:
Name: _____
Relationship: _____
Phone: _____

Primary Care Doctor
Name: _____
Address: _____
_____zip____
Phone: _____

INSURANCE INFORMATION

Primary Insurance: _____
ID Number: (Please Include Letters and Numbers) _____
Group Number: _____ Effective Date of Coverage: _____
Subscriber Information (If Other Than Yourself)
Name: _____ Date of Birth: _____ Relationship: _____

Secondary Insurance: _____
ID Number: (Please Include Letters and Numbers) _____
Group Number: _____ Effective Date of Coverage: _____
Subscriber Information (If Other Than Yourself)
Name: _____ Date of Birth: _____ Relationship: _____

Insurance Authorization: I herby assign all medical and/or surgical benefits to which I am entitled, including Medicare and any private health plan to: Raymond T. Pekala, M.D. I understand that I am financially responsible for any amount not covered by insurance or any amount deemed the subscriber's responsibility as defined by my insurance company, particularly co-payments and deductibles.

Signature: _____ Date: _____

NAME: _____DATE:_____

WHO REFERRED YOU HERE TODAY? _____

EYE PROBLEMS (PRESENT AND PAST): _____

MEDICAL PROBLEMS: _____
_____

MEDICINES: _____
_____

EYE DROPS (PLEASE INDICATE WHICH EYE, HOW OFTEN): _____
_____

ALLERGIES (INCLUDING DRUG ALLERGIES):
_____

SOCIAL HISTORY:

OCCUPATION: _____

DO YOU SMOKE? (Circle your smoking status)

Current every day smoker	Heavy Tobacco smoker
Current some day smoker	Light Tobacco smoker
Former smoker	Smoker, current status unknown
Never smoked	Secondhand Smoke

DO YOU DRINK ALCOHOL? Y___N___ HOW MUCH? _____

FAMILY HISTORY:

Y	N	DIABETES	Y	N	RETINAL DETACHMENT
Y	N	GLAUCOMA	Y	N	OTHER _____
Y	N	MACULAR DEGENERATION			

PREFERRED LANGUAGE:

RACE (circle one)

Other	Pacific Islander
American Indian or Alaska Native	White
Black or African-American	Unavailable
Asian	Declined/Unable to determine

ETHNICITY (circle one)

Other	Declined/Unable to determine
Hispanic/Latino	Non-Hispanic/Latino
Arab-American	Unavailable

NAME: _____ DATE: _____

REVIEW OF SYSTEMS – LIST ANY PROBLEMS IN ANY OF THE FOLLOWING AREAS (CIRCLE NO IF YOU HAVE NOT HAD ANY PROBLEM)

Y N GENERAL _____
Y N STOMACH &INTESTINE _____
Y N EAR, NOSE & THROAT _____
Y N KIDNEY, BLADDER, PROSTATE _____
Y N HEART _____
Y N BONES & JOINTS _____
Y N THYROID _____
Y N SKIN _____
Y N LUNGS _____
Y N NERVOUS SYSTEM _____
Y N MENTAL ILLNESS _____
Y N BLOOD _____

PHARMACY YOU WOULD LIKE TO USE

_____
_____
_____

Raymond T Pekala MD
Privacy Officer: Raymond Pekala
Effective Date: April 14, 2003

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to get a copy of your paper or electronic medical record, correct your medical record, request confidential information, ask us to limit the information we share, get a list of those with whom we have shared your information, get a copy of this privacy notice, choose someone to act for you, file a complaint if you feel your privacy rights have been violated.

Your Choices

You have some choices in the way that we use and share information as to whether or not we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory

We never market or sell your information.

Our Uses and Disclosures

We may use and share your information as we treat you, run our organization, bill for your services. We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health, safety issues, research, comply with the law, respond to organ donor requests, work with a medical examiner or funeral director. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**
We can also address workers' compensation, law enforcement, and other government requests. We can also respond to lawsuits and legal actions with instructions from the Court.

File a complaint if you feel your rights are violated

You can complain if you feel we have violated your rights by contacting
Raymond Pekala MD
215 White Horse Pike
Haddon Heights, NJ 08035
You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
We will not retaliate against you for filing a complaint.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Raymond T Pekala MD
Ophthalmology

Acknowledgement of Receipt
Of
Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I read, or was given the opportunity to read, this Notice and understood it.

Patient Name (please print)

Parent or authorized Representative (if applicable)

Signature

Date

RECORDS RELEASE

DATE: _____

TO: _____

I hereby authorize you to release to Raymond Pekala MD

☐ **99 West Gate Dr**
Cherry Hill, NJ 08034
Phone: 856-428-1400
Fax: 856-428-9358

☐ **215 White Horse Pike**
Haddon Heights, NJ 08035
Phone: 856-547-1646
Fax: 856-547-9138

Any information including the diagnosis and records of any treatment or examination rendered to me.

_____
Date

_____
Signature

_____
Address

_____
City, State, Zip