CHRISTOPHER N. SPELLMAN M.D., INC.
169 Saxony Rd. Suite 115 Encinitas, CA 92024
Phone: (760) 633-3377
Fax: (760) 633-3370

New Patient Registration

Title: _____ First Name: _____

Middle Initial: _____ Last Name: _____

Sex: _____ Marital Status: _____

Social Security No: _____ Date of Birth: _____

Address: _____

How Did you hear about our office: _____

Do you have a referring Physician? If yes, who: _____

Employer: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

E-Mail: _____

Primary Care Physician: _____

Insurance Company _____

Insurance Id: _____

Group Number: _____

Emergency Contact: _____

Emergency Contact Phone Number: _____

Relationship: _____

I authorize Christopher N. Spellman, M.D., Inc. to submit a claim to my medical insurance carrier or its intermediaries for all covered services or products provided by the practice. **I understand that I am responsible for any deductible, co-insurance, co-payment, and any non-covered services.** I understand that it is the policy of the practice to collect for these items at time of service. I understand the practice is able to refer my account to collections if I do not make payment. I understand that it is my responsibility to update my insurance file whenever I change insurance carriers. I understand that failing to provide current information will make me immediately responsible for balances otherwise paid by my medical carrier. I understand that if I join an HMO I will inform the practice prior to scheduling any care such that the staff can identify my eligibility for care with this practice. I have completed the above information and certify that it is true and correct to the best of my knowledge. I will notify this office of any changed in my health status or the above information.

Signature: _____

Date: _____

Christopher Spellman, M.D.
Ophthalmology

HIPAA Consent
Notice of Privacy Practices

I understand that as part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- 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 and reviewing the competence of healthcare professionals.

I understand that I have the right to review a *Notice of Information Practices* that gives a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions that the organization has already take action in reliance thereon.

Signature of Patient or Legal Representative:

_____

Date: _____

Christopher Spellman, M.D.
Ophthalmology

Medical History

Name:_____ Date: _____

Date of Birth: _____ Date of last eye exam: _____

List of Medications and dosage (prescription and/or over-the-counter):

_____
_____
_____
_____
_____

List major illnesses and/or injuries and their dates: _____
_____
_____

List any surgeries and their dates: _____
_____
_____

List any medications you are allergic to, if any: _____
_____
_____

General: Please check if you are currently experiencing any of these issues

Fever: Yes [] No []
Ear, Nose, Throat: Yes [] No []
Respiratory: Yes [] No []
Genital, Kidney, Bladder: Yes [] No []
Neurological: Yes [] No []
Endocrine: Yes [] No []
Allergic/Immunologic: Yes [] No []
Weight Loss: Yes [] No []
Cardiovascular: Yes [] No []
Gastrointestinal: Yes [] No []
Muscles, Bones, Joints: Yes [] No []
Psychiatric: [] Yes [] No
Blood/Lymph: Yes [] No []
Skin: Yes [] No []

Do you currently wear glasses or contacts? Yes [] No []
If yes, how long have you worn them?_____

Do you drink alcohol? Yes [] No []
If yes, how much: Occasionally [] 1 per week [] 1 per day [] 2 or more per day []

Do you smoke? Yes [] No []
If yes, how much: Occasionally [] 1 pack per week [] 1 pack per day [] 1 or more pack per day []

Have you ever had a blood transfusion? Yes [] No []

Family Medical History

Please check all applicable

Blindness: Yes [] No [] Self [] Mother [] Father [] Sibling [] Grandparent []

Glaucoma: Yes [] No [] Self [] Mother [] Father [] Sibling [] Grandparent []

Arthritis: Yes [] No [] Self [] Mother [] Father [] Sibling [] Grandparent []

Cancer: Yes [] No [] Self [] Mother [] Father [] Sibling [] Grandparent []

Diabetes: Yes [] No [] Self [] Mother [] Father [] Sibling [] Grandparent []

Heart Disease/High Blood Pressure: Yes [] No [] Self [] Mother [] Father [] Sibling[] Grandparent []

Kidney Disease: Yes [] No [] Self [] Mother [] Father [] Sibling [] Grandparent []

Lupus: Yes [] No [] Self [] Mother [] Father [] Sibling [] Grandparent []

Stroke: Yes [] No [] Self [] Mother [] Father [] Sibling [] Grandparent []

Thyroid Disease: Yes [] No [] Self [] Mother [] Father [] Sibling [] Grandparent []

Other: Yes [] No [] Self [] Mother [] Father [] Sibling [] Grandparent []

Additional Notes: _____

_____

_____

I understand that the information that I have provided today is accurate to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to advise your office of any changes in the information contained on this form.

Signature: _____

Date: _____