Suraj M. Cherry, MD
PATIENT REGISTRATION
PLEASE PRINT

Patient's Name: _____ Date of Birth: _____-_____-_____ Age: _____
Last First Middle

Address: _____ City: _____ State: ____ Zip: _____

Primary Phone: (_____) _____ Alternate Phone: (_____) _____

☐ Single ☐ Married ☐ Widowed ☐ Male ☐ Female Soc. Sec. # _____-_____-_____

E-Mail: _____ Driver's License #: _____

How were you referred to our practice? ☐ Family/Friend ☐ Doctor ☐ Insurance ☐ Phone Book
☐ Dr. Cherry's Staff ☐ Internet ☐ Other _____

Whom may we thank for referring you? _____

Patient's Employer: _____ **Occupation:** _____

Work Address: _____ City: _____ State: _____ Zip: _____

Work Phone: (_____) _____Ext.:_____

If the patient is a dependent or minor, the following pertains to the insured:

Insured's Name: _____ Relationship: _____

Insured's Employer's Name: _____ Phone: (_____) _____

Work Address: _____ City: _____ State: _____ Zip:_____

Insured's Soc. Sec. # _____-_____-_____ Insured's Date of Birth _____-_____-_____

Personal Physician: _____ Phone: (_____) _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Emergency Contact: _____ Phone: (_____) _____

Emergency Contact: _____ Phone: (_____) _____
(Not living with you)

AUTHORIZATION AND ASSIGNMENT OF INSURANCE BENEFITS

I hereby give consent and authorize the performance of all treatments, surgery and medical services by the physicians and staff which they may deem advisable and to furnish information relating to all claims for benefits submitted on my behalf and/or my dependents. I hereby assign all payments for medical services rendered or devices to be rendered. I understand that I am financially responsible for all charges whether or not they are covered by my insurance. A photocopy of this authorization shall be considered as effective and valid as the original.

Signature: _____ Date: _____ Relationship: _____

Patient's Name:_____ Date:_____

MEDICAL HISTORY

MAJOR ILLNESSES - Please place a check mark by any conditions you have now, or have had in the past:

❑ Arthritis	❑ Head Injury	❑ Seizures (Epilepsy)
❑ Cancer	❑ Heart Problems	❑ Thyroid Disease
❑ Diabetes	❑ High Blood Pressure	❑ Tuberculosis (TB)
❑ Hardening of the Arteries	❑ Kidney Disease	❑ Venereal Disease
❑ Headaches/Migraines	❑ Paralysis of Arms or Legs	

❑ Other:_____

Do you smoke? ❑ Yes ❑ No How much per day?_____

Do you drink alcohol? ❑ Yes ❑ No How much per day?_____

SURGERIES - Please list ALL surgeries that you have had, and the approximate dates:_____

_____

_____

MEDICATIONS - Please list ALL medications that you are CURRENTLY taking (including vitamins, hormones, birth control pills, and prescription medications):_____

_____

_____

MEDICATION ALLERGIES - Please list ANY medications to which you've had allergic reaction in the past:

_____

FAMILY HISTORY - Please check any conditions that blood relatives have, or have had:

❑ Cataracts	❑ Glaucoma	❑ Lazy Eye/Amblyopia
❑ Crossed/Crooked Eyes	❑ History of Eye Surgery	❑ Retinal Detachment/Degeneration
❑ Diabetes	❑ Heart Problems/Stroke	❑ Seizures

PERSONAL EYE HISTORY - Please check any eye conditions or treatments that you have had:

❑ Burning	❑ Dryness	❑ Pain
❑ Color Blindness	❑ Excessive Watering	❑ Sensitivity to Light
❑ Difficulty at night	❑ Floaters or Specks	❑ Temporary Vision Loss
❑ Discharge from eye	❑ Injury	❑ Trouble Reading
❑ Double Vision	❑ Light Flashes	❑ Trouble seeing far away

❑ Other:_____

Please list any drops or pills you are currently taking for your eyes (with or without a prescription):_____

_____

Have worn glasses for _____ years Current pair of glasses are _____ years old.

Wear glasses for: ❑ Reading only ❑ Driving only ❑ Full-time Date of last exam:_____

Was your prescription for glasses or contacts changed during that exam? ❑ Yes ❑ No

SURAJ M. CHERRY, MD
COMPREHENSIVE EYE CARE & SURGERY
DIPLOMATE OF THE AMERICAN BOARD OF OPHTHALMOLOGY

_____
Patient's Name & Date of Birth

ASSIGNMENT OF BENEFITS
Medicare and/or other insurance

I hereby authorize payment of medical, surgical and vision benefits to Suraj M. Cherry, MD. I authorize this office to release any information required to process all claims for reimbursement on my behalf. The above provider participates with Medicare and other insurances: therefore I understand that the patient is responsible for applicable deductibles, co-insurance, co-payments and non-covered services. I understand I am financially responsible for any charges incurred if my insurance is not in effect on the date of services. A copy of this authorization may be used in place of the original.

_____ _____
Patient signature Date
(Guardian signature for minors)

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REFRACTION AND CONTACT LENS POLICY

A refraction is a measurement of the lens power necessary to prescribe glasses or other corrective lenses. Most medical insurance plans, including Medicare, DO NOT cover refractions or contact lens evaluations. If you are interested in a new prescription for glasses or contact lenses, please inform the office staff so that the proper examination can be preformed.

_____ _____
Patient signature Date
(Guardian signature for minors)

3505 LONE TREE WAY, SUITE 6 ANTIOCH, CA 94509
PHONE: (925) 778-4555 FAX: (925) 778-3310