PATIENT REGISTRATION

Name: _____ Sex: □ Male □ Female Date of Birth: ____/____/_____ Age:_____

SS#_____ Marital Status: □ Single □ Married □ Widowed □ Divorced

Address _____City_____ State _____ Zip_____

Home Phone: (____) _____-_____ Cell: (_____) _____-_____ Email:_____

How would you like to be reminded for upcoming appointments? □ Phone call □ Email □ Text Message (__) _____-_____

How did you hear about our practice: □ Insurance Co. □ Website □ Doctor □ Other patient □ Radio □ Patient □ Print ad

Employer: _____Occupation: _____ Driving □ Yes □ No

Emergency Contact Name: _____Phone: (___) _____ Relation: ____ _____

Primary Care Physician: _____ Referring /Specialty Dr._____

Pharmacy:_____ Location (street & city) _____

Race: □ American Indian /Alaska Native □ Asian □ Black or African American **Ethnicity:** □ Hispanic
□ Native Hawaiian /Other Pacific Islander □ White □ Other □ Not Hispanic

Preferred Language: □ English □ French □ Italian □ Japanese □ Portuguese
□ Russian □ Spanish □ Vietnamese □ Polish □ Other _____

INSURANCE INFORMATION

Primary Insurance: _____ ID # _____

Policy holder: _____ Relationship to patient: _____

Secondary Insurance (if applicable) _____ ID # _____

Signature _____ Relation to Patient::_____ Date: _____/ _____/ ____

NOTICE OF PRIVACY PRACTICES: (Notice of Privacy Practices is the last page of this packet)

By signing below, I acknowledge that I have received and reviewed a copy of the "Notice of Privacy Practices" which describes how Eyesight and Surgery Associates may use and disclose my healthcare information and how I can gain access to my information.

My Medical Information may be shared with: _____ Relation _____

Address: _____ Phone number: _____

_____

Signature _____ Relation to Patient::_____ Date: _____/ _____/ _____
(if minor)

INFORMATION AND CONSENT FOR PUPIL DILATION

Pupil Dilation is essential for full medical evaluation of the eye. This requires the placement of multiple eye drops. Dilation causes an inability to focus on near objects or reading material, which can make close work very difficult. Dilation may cause difficulty driving or operating heavy machinery. These activities should only be done with great caution after dilation. Dilation may also cause some unsteadiness in walking. Please ask for assistance if you feel uncomfortable. These side effects can last for several hours afterward.

Very rarely, dilation of the pupils can induce a type of glaucoma in people who are susceptible to this problem. We check for signs that you might be predisposed to this type of glaucoma prior to receiving dilation drops. Signs of acute glaucoma include redness, severe pain, nausea, loss of vision. If any of these occur after dilation, you should call the office immediately.

I understand the above issues concerning dilation of the pupils. I give my consent for pupil dilation during any and all of my visits to this office if the doctor feels it is necessary.

Signature _____ Relation to Patient: _____ Date: _____/ _____/ _____
(If minor)

I refuse dilation knowing that my exam will be less comprehensive. (Sign Below)

Signature _____ Relation to Patient: _ _____Date: _____/ _____/_____

PATIENT MEDICAL HISTORY

Allergies: Reaction Severity

_____ mild / moderate / severe

_____ mild / moderate / severe

Past Ocular History: (Please mark all that apply)

□ None
□ Macular degeneration
□ Amblyopia (Lazy eye)
□ Aphakia
□ Astigmatism
□ Cataracts
□ Diabetic Retinopathy
□ Dry Eyes
□ Glaucoma
□ Hyperopia (Far sighted)
□ Iritis
□ Keratoconus
□ Myopia (Near sighted)
□ Optic Neuritis
□ Retinal Detachment

Other _____

Ocular Surgeries: (Please mark all that apply)

□ No prior ocular surgery
□ Blepharoplasty
□ Cataract Surgery
□ Corneal Transplant
□ Foreign Body Removal
□ Retinal Laser Surgery
□ LASIK
□ PRK
□ Punctual Plugs
□ RK
□ Strabismus Surgery
□ Trabeculectomy (Glaucoma surgery)
□ Vitrectomy

Other _____

Ocular Significant Illnesses: (Please mark all that apply)

□ None
□ Overall Healthy
□ AIDS
□ Diabetes
□ Rheumatoid Arthritis
□ Herpes
□ HIV Positive
□ Hypertension
□ Hypothyroidism
□ Lupus
□ Multiple Sclerosis
□ Sjogrens
□ Graves Disease
□ Hyperthyroidism

Other _____

Current Eye Medications: (Please list)

_____

_____

Systemic Illnesses

□ No history of illnesses
□ Anemia
□ Arthritis
□ Arrhythmia
□ Asthma
□ Bleeding Disorder
□ Cancer
□ Thyroid Disease
□ Congestive Heart Failure
□ COPD
□ Diabetes
□ Eczema
□ Fibromyalgia
□ Headache
□ Hearing Loss
□ Hepatitis
□ High Blood Pressure
□ High Cholesterol
□ HIV
□ Kidney Disease
□ Kidney Stones
□ Liver Disease
□ Lung Disease
□ Lupus
□ Migraine
□ Polymyalgia
□ Psychiatric Disorder
□ Skin Cancer
□ Stroke

Other _____

General Surgeries / Operations: (Please list)

_____

Current Other Medications: (Please list)

_____

_____

Infections:

□None
□ Overall Healthy
□ Chicken Pox
□ Hepatitis A / B / C
□ Herpes Simplex
□ Herpes Zoster / Shingles
□ Histoplasmosis
□ HIV / AIDS
□ Meningitis
□ MRSA
□ Syphillis
□ Toxoplasmosis
□ Wound Infection

Other _____

Social History: (Please mark all that apply)

Smoking: □ current every day smoker □ current some day smoker □ former smoker □ never smoked

Alcohol Use: □ Yes □ No If yes how much and how often?_____

Drug Use: □ Yes □ No If yes what and how often? _____

Family History:

□ None
□ Arthritis
□ Blindness
□ Cancer
□ Cataracts
□ Other _____
□ Diabetes
□ Glaucoma
□ Heart Disease
□ High Blood Pressure
□ Kidney Disease
□ Lazy Eye
□ Macular Degeneration
□ Retinal Disease
□ Stroke
□ TB

Review of Systems: (Please mark all that apply)

Eyes
- □ None
- □ Previous Surgery
- □ Contact Lens
- □ Pain
- □ Double Vision
- □ Glaucoma
- □ Cataracts
- □ Macular Degeneration
- □ Dry Eyes
- □ Flashes
- □ Floaters

Ear, Nose, and Throat
- □ None
- □Ringing in Ears
- □ Vertigo
- □ Hard of Hearing

Cardiovascular
- □ None
- □ Chest Pain
- □ Dizziness
- □ Fainting Spells
- □ Shortness of Breath
- □ Irregular Heart Beat
- □ Difficulty Lying Flat

Constitutional
- □ None
- □ Fever
- □ Weight Gain / Loss

Respiratory
- □ None
- □ Cough
- □ Congestion
- □ Wheezing
- □ Asthma

Gastrointestinal
- □None
- □Heartburn
- □ Nausea / Vomiting
- □ Jaundice / Hepatitis

Genito-Urinary
- □ None
- □ Pain / Difficulty
- □ Blood in Urine
- □ History of Kidney Stones
- □ History of STD's

Psychiatric
- □ None
- □ Anxiety / Depression
- □ Mood Swings
- □ Difficulty Sleeping

Endocrine
- □ None
- □ Increased Thirst
- □ Increased Hunger
- □ Increased Urination
- □ Increased Sweating
- □ Fingernail Changes

Blood / Lymphnodes
- □ None
- □ Easy Bruising
- □ Gums Bleed Easy
- □ Prolonged Bleeding
- □ Heavy Aspirin Use

MusculoSkeletal
- □ None □ Stiffness
- □ Arthritis
- □ Joint Pain / Swelling

Skin
- □ None
- □ Rash / Sores
- □ Lesions
- □ Hives / Eczema

Neurological
- □ None
- □ Seizures
- □ Weakness / Paralysis
- □ Numbness
- □ Tremors

Immunologic
- □ None
- □ Hives
- □ Itching
- □ Runny Nose
- □ Sinus Pressure

INSURANCE/OFFICE POLICES

Insurance: I request that payments of authorized insurance benefits be made on my behalf directly to Eyesight and Surgery Associates for any service furnished to me by a physician or allied health professional employed by that corporation. I authorize release of any medical information necessary to determine those benefits. I am aware that I will be responsible for money not paid by my insurance, including but not limited to deductibles, co-pays, and uncovered services. I understand that my symptoms and the doctor's findings during my exam will determine how my exam is billed to my insurance. It is my responsibility to know the details of my plan, including deductibles, co-payments, and routine vision coverage.

Cancellations/No Shows: We require that you call our office at least 24 hours prior to your scheduled appointment if you need to cancel or reschedule. We reserve the right to charge or dismiss a patient for missed appointments without notice. If you are more than 15 minutes late for your appointment, we may ask you to reschedule your appointment.

Changes: You are responsible to notify our office of any changes with your address, phone number, or insurance information.

Referrals: You are responsible for obtaining your insurance referrals, as required by your insurance policy. If your insurance denies your visit, you will be responsible for unpaid balances

Financial Agreement: I understand that I am financially responsible for any charges incurred for services provided. If I have out of network benefits and my provider is out of network, I understand that I will be responsible for higher co-insurance, deductibles, and co-payments. If I choose to have non-covered services performed, I will be responsible for the full payment of those charges. If my account is sent to collections for lack of payment I agree to pay my provider's fees and expenses incurred in collecting any such amounts, including without limitation, attorney's fees and costs.

Returned Checks: We reserve the right to charge you for a returned check for any services. There is a $25.00 fee for all returned checks, for each occurrence. We reserve the right to no longer accept checks as form of payment from any person whose check does not clear. Checks that are returned for closed accounts will be reported to the authorities.

After Hours On Call Service: We do provide after hours telephone triage advice given by one of our doctors. This is for medical eye emergencies only. Please call during regular office hours for things such as prescription refills, contact lens replacement, and contact lens and glasses prescriptions.

I have reviewed the insurance and office policies, and fully understand and agree to the policies as listed.

Signature _____ Relation to Patient: _____ Date: _____/ _____/ _____

(If minor)

EYE EXAM POLICY

Routine Eye Examinations: A general screening of the overall health of your eyes with no medical problems or complaints.

Medical Eye Examinations: An eye examination where you are being evaluated for and/ or treated for a medical condition or symptom that you describe to our staff, or a condition that the doctor finds during the examination. Examples include: *headache, diabetes, eye irritation, dry eyes, allergies, contact lens intolerance, glaucoma, cataract, macular degeneration, etc.*

Vision Plans/Vision Benefits: Typical coverage includes an eye examination and a pair of eyeglasses or contact lenses once every 12-24 months. The exam benefit is only used to update your eyeglass or contact prescription and not treat any medical eye issues. If during your visit, the doctor identifies an eye problem, disease, or injury, your visit will be billed to your medical insurance. You will be able to use your routine benefit at a later date.

Refraction: The refraction test provides the doctors information about the function of your eyes and may alert the doctors of any problems that may be related to a decrease in your vision. This test is also necessary if you wish to get an updated eyeglass or contact lens prescription. If you do not have routine exam coverage or a separate vision plan, there is a $50 fee for this service, in addition to your copayment or other fees your insurance policy dictates. We offer a $5 discount if you pay for this on the date of your exam, making it $45. The fee is not covered under most insurance plans. If your insurance pays the fee, we will reimburse you accordingly.

Please Check one:

- □ I do NOT have a separate vision plan or vision coverage through my medical insurance
- □ I do have vision coverage under my medical plan
- □ I do have vision coverage through a separate vision plan

If you determine that you have a vision plan after your exam has been completed, the exam will not be able to be resubmitted.

Signature _____ Relation to Patient: _____ Date: ____/ ____/ ____