Patient Registration

Please complete the following Information.

Patient Name			Salutation	
Date of Birth		Age		
Sex			SS #	
Address				
City, State			Zip	
Occupation			Employer	

COMMUNICATION

Preference					
Home Phone #		Work Phone #		Extension	
Cell Phone #		Carrier			
Email					

GOVERNMENT MANDATED INFORMATION

Plan Type		HIPAA Signed	
Primary Language		Special Needs\Wheelchair	
Race		Ethnicity	
Marital Status		Mother's Maiden Name	
		Birth State	

ACCOUNT RESPONSIBLE

Responsible				Salutation	
Relationship				SS #	
Address					
Home Phone #		Work Phone #		Extension	
Email					

PRIMARY INSURANCE

Name of Insurance		Group Name	
ID #		Group #	
Address			
Phone			
Insured		Date of Birth	
Copay			

SECONDARY INSURANCE

Name		Group Name	
ID #		Group #	
Phone			
Insured		Date of Birth	

Dilation Consent

Dilation of the pupils is strongly recommended by our doctors in order to fully evaluate the health of the eyes. This procedure enables the doctor to obtain a more thorough view of the back of the eye and detect my diseases and potentially sight-threatening conditions that may not otherwise be detected. The main side effects of dilation are increase sensitivity to bright lights and blurry vision, especially at near. The procedure is painless and the effects last approximately two to four hours. Most, but not all patients are still able to drive while their eyes are dilated.

Please circle one

Yes, dilate my eyes No, do not dilate my eyes

Payment Policy: Payments from medical services are due on the day of services.
Payments for optical goods are due on the day the order is placed. Payment includes all co-payments, co-insurance, deductibles and non-covered items. If current insurance information is not provided at the time of service the amount due will be the patients responsibility. If the insurance company denies payment for services or optical goods, the patient will be responsible for the remaining unpaid balance.

Insurance Authorization and Assignment of Benefits:In I request that payment of authorized Medicare/other Insurance company benefits be made on my behalf to 20/20 Eyecare, PSC for any services or supplies furnished to me by 20/20 Eyecare, PSC. Regulations pertaining to Medicare Assisgnments of benefits apply. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing administration or its intermediaries or carriers any information needed for this or a related Medicare claim/other Insurance company chain. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to 20/20 Eyecare, PSC. I understand it is mandatory to notify the health care provider of a any other party who is responsible for payment for my treatment.

Privacy Practices: My signature below confirms that I have received/had made available to me the "Notice of Privacy Practices", and its explanation of how 20/20 Eyecare, PSC will use my personal health information in relation to treatment, payment and healthcare operations, as well as my rights regarding the management of this information. I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provision effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice Of Privacy Practices on request. I understand that as part of this organization's treatment, payment or health care operations, it may become necessary to disclose my protected health information to another entity and I consent to such disclosure for these permitted uses, including disclosures via fax.

I understand that I must give written permission for 20/20 Eyecare, PSC to disclose any information to my spouse or a family member. I hereby give 20/20 Eyecare, PSC permission to disclose my personal health information to:

List names to disclose your personal health information to:

Name: ____________________ Number: ____________
Name: ____________________ Number: ____________

Please sign below: Your signature is verification that you have read and fully understand the above information:

Signature: ____________________ Date: ____________________

Are you interested in glasses? Y or N
Are you interested in contacts? Y or N

Would you like for us to make an appointment for next year's exam? Y or N

PATIENT HEALTH HISTORY

Patient Name		Birthdate	

Reason for Visit: (Circle all that apply)

Routine Exam, No Complaints
Cataract Evaluation
Other ____________________

Contact Lens Exam
Eye Problem (Specify below)

School Exam
Diabetic Evaluation

REVIEW OF SYSTEMS	
Do you currently have any of the following problems?	Please specify
Constitution (chronic fever,unexpected weight loss/gain, fatigue)	Y or N
Cardiovascular (high blood pressure, cholesterol, heart attack)	Y or N
Ears, Nose, Mouth, Throat (hearing loss, sinus problems, sore throat)	Y or N
Respiratory / Lungs (asthma, shortness of breath, wheezing)	Y or N
Stomach / Intestines (heartburn, abdominal pain, diarrhea)	Y or N
Urinary / Reproductive (STD, blood in urine, kidney function)	Y or N
Bones / Joints / Muscles (arthritis, multiple sclerosis, swollen joints)	Y or N
Skin / Hair / Nails (rash, loss of hair)	Y or N
Neurological (headaches, stroke, paralysis, seizures)	Y or N
Psychiatric (depression, anxiety, ADHD)	Y or N
Endocrine / Hormonal (diabetes, thyroid problems)	Y or N
Blood / Circulation (Anemia, clotting disorders, lymphoma)	Y or N
Allergic / Immunologic	Y or N
Other	Y or N

EYE SURGICAL INFORMATION				
Date	Eye	Procedure	Surgeon	Complications

PAST / PRESENT OCULAR HISTORY		
		Date Diagnosed
Glaucoma	Y or N	
Cataracts	Y or N	
Age-Related Macular Degeneration	Y or N	
Eye Injury	Y or N	
Retinal Disease	Y or N	
Other Disease	Y or N	
Blindness	Y or N	
Strabismus	Y or N	
Amblyopia	Y or N	
Diabetes	Y or N	
Dry Eye	Y or N	
Refractive	Y or N	
Other	Y or N	

SOCIAL HISTORY	
What type of recreational drugs do you use?	
What type of alcohol do you drink, how much and how often?	
Are you a smoker, former smoker or never smoked? Do you smoke everyday or some days?	
What type of tobacco do you use, how much, how often and for how long?	
Do you work on a computer? Hours per day?	Y or N
Are you Pregnant?	Y or N
Hobbies (ex. Skiing, Shooting, Fishing, Sports, Sewing, riding bicycle/motorcycle)	

FAMILY HISTORY	
Please list any family members with these conditions MGM (maternal grandmother) PGM (paternal grandmother) MGP (maternal grandparents) MGF (maternal grandfather) PGF (paternal grandfather) PGP (paternal grandparents)	
Glaucoma	
Cataracts	
Age-Related Macular Degeneration	
Eye Injury	
Retinal Disease	
Other Disease	
Blindness	
Strabismus	
Amblyopia	
Diabetes	
Cancer	
Heart Disease	
Other	

ALLERGIES		
Allergy	Reaction	Severity

CURRENT MEDICATIONS			
Please list all prescriptions, over the counter and herbal medications			
Date	Name	Date	Name

Please sign:

Signature: ______________________________ Date: ___________________________