# The Eye Center Confidential Internal Patient Registration Form

**Patient Information** □ New Patient □ Previous Patient **Today's Date**:_____

Patient Name: (Last)_____(First)_____

Street: _____

City: _____ State:_____ZIP_____

Daytime Phone # _____ Cell Phone # _____

Email Address: (**please print**)_____

Birth date: _____ Gender: □ Male □ Female

Marital Status: □ Single □ Married □ Divorced □ Widowed

Employment Status: □ FT □ PT □ Self Employed □ Retired □ Student

Employer: _____ Occupation: _____

Preferred language: _____ ( i.e.- english, spanish, chinese etc. )

Race: □ Asian □ Black or African American □ Hispanic □ Eastern Indian □ White
□ Native Hawaiian/other Pacific Islands □ American Indian or Alaska Native

Ethnicity: □ Hispanic or Latino □ Native Hawaiian/other Pacific Islands □ Not Hispanic or Latino

Communication Pref: □ Email □ Telephone □ Postal

Emergency Contact Name_____Phone Number _____

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A Routine Eye Examination (covered by Vision Insurance Plans) covers a prescription to address the following vision conditions: Near-Sightedness, Far-Sightedness, Astigmatism and Presbyopia. All other causes of decreased vision as well as other problems and complaints (such as those listed below), may be billed medically after discussing them with the Doctor and result in higher fees.

## Which of the following problems are you noticing? (**Check** *all that apply)*

| | | | |
|---|---|---|---|
| □ Blurred vision | □ Blurred near vision | □ Double vision | □ Eyestrain |
| □ Night vision difficulty | □ Headache | □ Redness | □ Watering |
| □ Itching | □ Burning | □ Dryness | □ Eye pain |
| □ Sandy/gritty feeling | □ Flashes or floaters | | |

**PAST OCULAR HISTORY:** List any of the following that you have had -

Crossed eyes, lazy eye, eye infections, eye surgeries, eye injury, glaucoma, cataracts, retinal disease

_____

_____

Are you pregnant? □ No □ Yes

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## Medical History: Please note any history of the following conditions:

| Disease/Condition | Self | Relative | None | Disease/Condition | Self | Relative | None |
|---|---|---|---|---|---|---|---|
| Blindness | □ | □ | □ | Heart Disease | □ | □ | □ |
| Cataract | □ | □ | □ | High blood pressure | □ | □ | □ |
| Crossed eyes | □ | □ | □ | Cancer | □ | □ | □ |
| Glaucoma | □ | □ | □ | Kidney disease | □ | □ | □ |
| Macular Degeneration | □ | □ | □ | Lupus | □ | □ | □ |
| Retinal Detachment | □ | □ | □ | Thyroid | □ | □ | □ |
| Diabetes | □ | □ | □ | Arthritis | □ | □ | □ |

Other _____

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## Medications:

Do you have any allergies to medication: □ No □ Yes If yes, explain _____

_____

Allergy to Iodine or shell fish: □ No □ Yes

Eye drops: _____

Prescription medications: _____

_____

Primary Care Physician:_____Phone: _____

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## Social History:

Tobacco Use: □ Never smoked □ Former smoker □ Current everyday smoker
Alcohol Use: □ None □ Social use only □ 1-2 drinks daily □ Above average
Narcotic Use: □ None □ Social use only
Sexually Transmitted Disease: □ No □ Yes □ HIV positive □ Other_____

**Review of Systems**: Do you currently, or have you ever had any problems in the following areas:

| | Yes |
|---|---|
| **Constitutional** | |
| Fever, weight loss/gain | ☐ |
| **Integumentary** | |
| Skin | ☐ |
| **Neurological** | |
| Headaches | ☐ |
| Migraines | ☐ |
| Seizures | ☐ |
| **Endocrine** | |
| Thyroid/other glands | ☐ |
| **Ear, Nose, Mouth, Throat** | |
| Allergies/hay fever | ☐ |
| Sinus congestion | ☐ |
| Runny nose | ☐ |
| Post-nasal drip | ☐ |
| Chronic cough | ☐ |
| Dry throat/mouth | ☐ |
| **Respiratory** | |
| Asthma | ☐ |
| Chronic bronchitis | ☐ |
| Emphysema | ☐ |

| | Yes |
|---|---|
| **Vascular/Cardiovascular** | |
| Diabetes | ☐ |
| Heart Pain | ☐ |
| High blood pressure | ☐ |
| Vascular disease | ☐ |
| **Gastrointestinal** | |
| Chronic diarrhea | ☐ |
| Chronic constipation | ☐ |
| **Genitourinary** | |
| Genitals/kidney/bladder | ☐ |
| **Bones/Joints/Muscle** | |
| Rheumatoid arthritis | ☐ |
| Muscle pain | ☐ |
| Joint pain | ☐ |
| **Lymphatic/Hematologic** | |
| Anemia | ☐ |
| Bleeding problems | ☐ |
| **Psychiatric** | ☐ |

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**Insurance Information:**

Relationship to Insured Party: ☐ Self ☐ Spouse ☐ Dependent ☐ Child ☐ Other

**Vision Insurance**: _____ ID #: _____

Primary Card Holder Name/**date of birth:** _____

**Medical Insurance**: _____

Primary Card Holder Name/**date of birth**: _____

ID #: _____ Group #: _____

Secondary Insurance Name: _____ID #: _____

Primary Card Holder Address (if differs from above) _____

_____

**The Eye Center Financial Responsibility**

Thank you for choosing the Eye Center for your eye care needs. We are happy to serve you, and look forward to a long relationship with you, our valued patient. In an effort to serve you efficiently, we have instituted the following financial policy. The policy below outlines the understanding between you, the patient, and our office. Our office will, as a courtesy, file your insurance claims based upon the information you provided on your registration sheet; however, it is your responsibility to provide us with complete and accurate information. You will be asked to provide this information on an annual basis. Failure to provide information necessary and required by the insurance company will result in the denial of your claim. Insured parties are expected to know their plan requirements and to abide by any specifications of their insurance plan. Furthermore, if information is requested from you, by the insurance company, you must provide that information promptly. If your claim is denied, it becomes your responsibility to pay the balance in full. By signing below, you understand that you will be responsible for the payment of any services not paid by the insurance company which includes co-payments, deductibles, coinsurance, and non-covered services and denied services not covered by contract by our office and your insurer. We will assist you in any way possible to be sure the claim is handled properly; we will file your insurance claim for you, and send a reminder statement when there is a balance to be paid by you. In instances where it is deemed necessary, we reserve the right to refer uncollected balances to an outside collection agency. By keeping open lines of communication and by providing accurate information, you can be sure your claims will be handled promptly and efficiently.
**The Eye Center requires that all exam fees and co-pays be paid in full at time of service, and a deposit of 50% when ordering materials.**
Thank you in advance for your cooperation.
By signing below, I agree that I am ultimately responsible for payment of services provided to me. My signature below authorizes The Eye Center to release the information necessary to facilitate the payment of medical claims.

**Signature** _____**Date** _____

## HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy as a patient. Implementation of HIPAA requirements officially began on April 14, 2003. While we have followed these policies for years, there have been a few updates that we wanted you to be aware of. This is a shortened version of the HIPPA policy. The full policy is available for your review in the reception area.

There are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal exchange of information within our office. HIPAA provides certain rights and protections to you as the patient. We follow these guidelines and provide you with the quality care you deserve. Additional information is available from the U.S. Department of Health and Human Services. You can find them online at www.hhs.gov

By signing below, I agree that, I have been offered the HIPPA policy, and understand and acknowledge my agreement to the terms set forth in the HIPPA information and consent form and any future updates to this policy.

Signature:_____