EYE ASSOCIATES, P.C.
PATIENT REGISTRATION

ACCOUNT NUMBER________________________________

DATE ____

LAST NAME: ___________________________________

FIRST NAME: __________________________________

MIDDLE: _____________________________________

ADDRESS: ____________________________________

CITY/TOWN/ST/ZIP: _____________________________

PHONE (HOME): _______________________________

PHONE (CELL):_________________________________

EMAIL ADDRESS: ______________________________

DATE OF BIRTH:________________________________

PLEASE CIRCLE: MALE FEMALE

PRIMARY CARE: _______________________________

SPECIALIST: __________________________________

ADDRESS: ____________________________________

PHONE NUMBER: ______________________________

RESPONSIBLE PARTY

NAME: ______________________________________
(OTHER THAN PATIENT)

ADDRESS: ____________________________________
(IF DIFFERENT FROM PATIENT)

PATIENT OCCUPTION: ___________________________

NAME OF COMPANY: ____________________________

ADDRESS: ____________________________________

EMPLOYER PHONE NUMBER: ______________________

INSURANCE INFORMATION:

NAME OF SUBSCRIBER ___________________________

IN CASE OF EMERGENCY PLEASE NOTIFY:

NAME: ______________________________________

ADDRESS: ____________________________________

PHONE: ______________________________________

SIGNATURE FOR ASSIGNMENT OF INSURANCE BENEFITS

____

We are required to ask for Ethnic origin and language; you are not obligated to answer:

LANGUAGE: **circle**

ARABIC	CANTONESE	CHINESE	ENGLISH
FRENCH	GERMAN	GREEK	GUJARATI
HINDI	ITALIAN	JAPANESE	KOREAN
MANDARIN	PORTUGUESE	RUSSIAN	SPANISH
TAGALO	VIETNAMESE		

PATIENT DECLINED: ___________________

RACE: **circle**

ALASKA NATIVE AMERICAN INDIAN
ASIAN BLACK OR AFRICAN AMERICAN
NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
WHITE/CAUCASIAN

PATIENT DECLINED: ___________________

UNKNOWN: __________________________

ETHNICITY: **circle**

HISPANIC NON HISPANIC UNKNOWN

Revised 2018

EYE ASSOCIATES, P.C.

PATIENTS NAME: ______________________________

EXTENDED HISTORY:

____

____

____

DATE OF LAST PHYSICAL: ______________________________

MEDICATIONS ☐ NO MEDICATIONS ☐

If any, please list all medications that you are taken with specific name and dosage:

____

____

____

____

____

____

____

____

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES ☐ NO ☐

IF YES, PLEASE LIST: ______________________________

DATE OF LAST EYE EXAM: ______________________________

DO YOU WEAR GLASSES? YES ☐ NO ☐

DO YOU WEAR CONTACT LENS? YES ☐ NO ☐

HAVE YOU EVER HAD MAJOR EYE SURGERY, MAJOR ILLNESS OR HOSPITALIZATION? YES ☐ NO ☐

IF YES, PLEASE EXPLAIN:

____

____

____

____

IS THERE ANY HISTORY IN YOUR FAMILY OF:

☐ YES ☐ NO GLAUCOMA

☐ YES ☐ NO CATARACTS

☐ YES ☐ NO LAZY EYE OR MUSCLE IMBALANCE

☐ YES ☐ NO RETINAL DISEASE

☐ YES ☐ NO OTHER

HAVE YOU NOW OR EVER HAD PROBLEMS WITH:

☐ YES ☐ NO DIABETES MELLITUS (ENDOCRINE)

☐ YES ☐ NO HIGH BLOOD PRESSURE/HEART

☐ YES ☐ NO EAR, NOSE, THROAT

☐ YES ☐ NO LUNGS

☐ YES ☐ NO KIDNEYS

☐ YES ☐ NO MUSCLE

☐ YES ☐ NO STOMACH OR INTESTINES

☐ YES ☐ NO ARTHRITIS

☐ YES ☐ NO NEUROLOGIC YES NO SKIN

☐ OTHER:

____

HAVE YOU EVER HAD:

☐ YES ☐ NO EYE INJURY

☐ YES ☐ NO EYE INFECTION

☐ YES ☐ NO EYE SURGERY

PLEASE CIRCLE ANSWERS BELOW:

DO YOU SMOKE YES NO

DID YOU GET A FLU SHOT YES NO

DID YOU GET PNEUMONIA SHOT/VACCINE YES NO

EYE ASSOCIATES, P.C.

Patient Name: ________________________________DOB: ____________MR: ___________

PATIENT AUTHORIZATION TO SHARE HEALTHCARE INFORMATION

I authorize Eye Associates to share my Medical information to the following individuals:

1. Name: ____________________________Address: _________________________________

   Phone Number: __________________Relationship to patient: ___________________________

   Expiration date: ___________________________

2. Name: ___________________________Address: _________________________________

   Phone Number: ____________________Relationship to patient: __________________________

   Expiration date: ___________________________

Please list any restriction of disclosure below:

____

____

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the **Federal HIPAA Privacy Act**. I have rights to revoke this authorization in writing except to the extent that the covered entity has acted in reliance upon the authorization.
My written revocation must be submitted to the Privacy Officer at the covered entity.

****

FINANCIAL POLICY RESPONSIBILITY

Should I receive a bill requesting payment for services rendered I accept full responsibility for payment in full.

Account Number: ____________________________________**Office will complete account number**

****

LEAVING VOICE MAIL MESSAGE

I, ___________________________________ authorize Eye Associates to leave a voice mail message on my cell/home phone number ______________________ informing me of an appointment, test results, rescheduling, or other information pertaining to my eye care.

****

ACKNOWLEDGEMENT OF HIPAA

I hereby acknowledge that I have been given the opportunity to read the Notice of Privacy Practices

****

SIGNATURE OF PATIENT ___________________________________DATE: ______________

EYE ASSOCIATES, P.C.
SIGNATURE ON FILE
MEDICARE

____

BENEFICIARY'S NAME (print)   MEDICARE IDENTIFICATION NUMBER

I request that payment of authorized Medicare Benefits be made on my behalf to **Eye Associates, PC** for services furnished me by **Eye Associates, PC**.

I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in item 9 of the HCFA 1500 for or elsewhere on other approved claim forms; my signature authorizes releasing the information to the insurer or agency shown.

EYE ASSOCIATES, PC accepts the charges determination of the Medicare carrier,

______________________________________, as the full charge, and the patients is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

____

SIGNATURE   DATE