

# Welcome!

## PATIENT REGISTRATION

Last Name \_\_\_\_\_

First Name \_\_\_\_\_ Title: Mr. Mrs. Ms. Dr.

Preferred Name: \_\_\_\_\_

Marital Status: Single \_\_\_ Married \_\_\_ Other \_\_\_

Patient Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone Number \_\_\_\_\_

Work Phone Number \_\_\_\_\_

Cell Phone Number \_\_\_\_\_

E-mail Address \_\_\_\_\_

Sex:  M  F Birthdate \_\_\_\_\_

Social Security Number \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

## INSURANCE

Who is the responsible party? \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Address \_\_\_\_\_

Employer \_\_\_\_\_

Work Phone Number \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Vision Insurance \_\_\_\_\_

ID# \_\_\_\_\_ Plan/Grp# \_\_\_\_\_

Medical Insurance \_\_\_\_\_

ID# \_\_\_\_\_ Plan/Grp# \_\_\_\_\_

## IN CASE OF EMERGENCY, CONTACT

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Contact Numbers \_\_\_\_\_

## MEDICATIONS

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

Drug Allergies \_\_\_\_\_

## PRIMARY CARE PHYSICIAN INFORMATION

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_ Last Eye Exam \_\_\_\_\_

Referred by:  Patient If so whom? \_\_\_\_\_

Newspaper  Television  Radio  Internet

Yellow Pages  Provider Book

Another Doctor If so whom? \_\_\_\_\_

## ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with \_\_\_\_\_ and assign directly to Primary Eyecare Group all insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance.** I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions. An interest rate of 1 ½ % per month will be applied to all balances over 30 days. Patient agrees to pay all expenses of collection including reasonable attorney fees.

Responsible Party Signature \_\_\_\_\_ Date \_\_\_\_\_

## MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to Primary Eyecare Group for services furnished me by Primary Eyecare Group. I authorize any holder of medical information about me to release to the Division of Medicare and Medicaid Services and its agents any information needed to determine those benefits payable of 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 form, or else where on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature \_\_\_\_\_ Date \_\_\_\_\_

## MEDICAL HISTORY QUESTIONNAIRE

### FAMILY HISTORY

Please note any family member with the following diseases/conditions:

M - Mother F - Father S - Sibling GP - Grandparent

	YES	NO		YES	NO
Arthritis	___	___	Diabetes	___	___
Blindness	___	___	Glaucoma	___	___
Cancer	___	___	Heart Disease	___	___
Cataracts	___	___	Hypertension	___	___
Crossed Eyes	___	___	Macular Deg.	___	___

### SOCIAL HISTORY

Health Habits

Check which substances you use and the consumption

	YES	NO	
Alcohol	___	___	Quantity: _____
Drugs	___	___	Quantity: _____
Tobacco	___	___	Quantity: _____

Please list any hobbies or special interests: \_\_\_\_\_

### REVIEW OF SYSTEMS

Check the symptoms and/or condition you currently have or have had in the past.

	YES	NO	UNKNOWN		YES	NO	UNKNOWN
<b>EYES</b>				<b>GASTROINTESTINAL</b>			
Blurred Vision	___	___	___	Constipation	___	___	___
Burning	___	___	___	Diarrhea	___	___	___
Cataracts	___	___	___	Ulcers	___	___	___
Crossed Eyes	___	___	___	<b>GENITOURINARY</b>			
Distorted Vision	___	___	___	Chlamydia	___	___	___
Double Vision	___	___	___	Gonorrhea	___	___	___
Dryness	___	___	___	Kidney Disease	___	___	___
Excess Tearing/Watering	___	___	___	Syphilis	___	___	___
Eye Pain or Soreness	___	___	___	<b>INTEGUMENTARY (skin)</b>			
Flashes/Floaters in Vision	___	___	___	Eczema	___	___	___
Foreign Body Sensation	___	___	___	Psoriasis	___	___	___
Glare/Light Sensitivity	___	___	___	<b>LYMPHATIC/HEMATOLOGIC</b>			
Glaucoma	___	___	___	Anemia	___	___	___
Infection of Eye or Lid	___	___	___	Bleeding Disorder	___	___	___
Itching	___	___	___	Hepatitis	___	___	___
Lazy Eye	___	___	___	Herpes	___	___	___
Loss of Vision	___	___	___	HIV Positive	___	___	___
Mucous Discharge	___	___	___	Liver Disease	___	___	___
Redness	___	___	___	<b>NEUROLOGIC</b>			
Retinal Disease	___	___	___	Epilepsy	___	___	___
Sandy or Gritty Feeling	___	___	___	Headaches	___	___	___
Styes or Chalazion	___	___	___	Migraines	___	___	___
<b>BONE/JOINT MUSCLE</b>				Multiple Sclerosis	___	___	___
Arthritis	___	___	___	Seizures	___	___	___
Joint/Muscle Pain	___	___	___	<b>PSYCHIATRIC</b>			
Polio	___	___	___	Depression	___	___	___
<b>CANCER</b>				High Anxiety	___	___	___
Breast	___	___	___	<b>REPRODUCTIVE</b>			
Lung	___	___	___	Nursing Mother	___	___	___
Prostate	___	___	___	Pregnant	___	___	___
Skin	___	___	___	<b>RESPIRATORY</b>			
<b>CONSTITUTIONAL</b>				Asthma	___	___	___
Fever	___	___	___	Chronic Bronchitis	___	___	___
Weight Gain/Loss (sudden)	___	___	___	Emphysema	___	___	___
<b>ENDOCRINE</b>				Pneumonia	___	___	___
Thyroid Abnormalities	___	___	___	Tuberculosis	___	___	___
<b>EAR, NOSE AND THROAT</b>				<b>VASCULAR</b>			
Allergies	___	___	___	Diabetes	___	___	___
Chronic Cough	___	___	___	Heart Disease	___	___	___
Dry Mouth/Throat	___	___	___	High Blood Pressure	___	___	___
Hay Fever	___	___	___	High Cholesterol	___	___	___
Runny Nose	___	___	___	Stroke	___	___	___
Sinus Congestion	___	___	___				