Patient Registration Form

PERSONAL INFORMATION (Please Print)

Name _____ Date _____

If minor, Responsible Parent Name: _____ *Date of Birth:* _____

Date of Birth _____Age _____ ☐ M / ☐ F Social Security #_____

Address _____

Street City State Zip

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

Email:_____

Please specify a contact preference: Do You Prefer we call your home or cell number? Circle One: ***HOME / CELL***

Occupation _____ Employer _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Decline to specify

Primary Care Physician Name:_____ Phone#:_____

Referred by: ☐ Doctor _____ **OR** ☐ Friend/Relative _____

Address_____ Phone (____) _____

Pharmacy Name_____ Address_____ Phone (___)_____

MEDICAL INSURANCE INFORMATION

Primary Insurance _____

Insured Party's Name: _____ ID#:_____

Relationship to Insured: Self / Spouse / Child / Other_____

Secondary Insurance (if any): _____

Insured Party's Name: _____ ID#: _____

Relationship to Insured: Self / Spouse / Child / Other_____

EMERGENCY CONTACT

Name _____ Relationship _____

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

FINANCIAL ASSIGNMENT AND AGREEMENT:

1. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance – including refraction fees of $60**
2. **In Order To Control Your Cost of Billings, We Request That Your Charges For Office Visits Be Paid At The Conclusion Of Each Visit Unless You Are Covered By Medicare.**
3. I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration, its agents, or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services.
4. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signed (Patient or parent if minor) _____ Date _____

Medical History

NAME: _____ **DATE OF BIRTH:** _____

Do you ***currently*** have any of the following? If yes, please detail.

	YES	NO	Details
Eye History			
Cataracts			
Glaucoma			
Dry Eyes			
Eye Surgery/Laser			
Eye Injury			
Other			
Medical History			
Diabetes			
Hypertension / Heart Disease			
Allergies			
Stroke			
Asthma / COPD			
Kidney Disease			
Arthritis			
Migraines			
Other			
Are you currently pregnant?			

List any **medications** you currently take (prescription and over-the-counter): _____

_____

Family History M = mother F = father S = sibling GP = grandparent

Disease	YES	NO	Relationship to Patient
Blindness / Glaucoma / Cataract			
Diabetes Stroke			
Heart disease/ high blood pressure/kidney disease			
Stroke			
Arthritis			
Thyroid disease			
Cancer			
Other			