Patient Registration

Full Name of Patient: ____________________

Responsible Party if Minor: ____________________ Relation: __________

DOB: ___/___/_____ SSN: _____-_____-_____ DL #: ______________ Sex: M or F

Patient Mailing Address: ____________________

Cell Phone: __________ Home Phone: __________ Work Phone: __________

Preferred Contact Number: __________ Email Address: __________

Current Place of Employment: ____________________

Occupation (Past if Retired): ____________________

Primary Language: __________ Marital Status: Single Married Widowed Divorced

Spouse's Name: __________ Spouse's Contact Number: __________

Emergency Contact Other Than Spouse: __________ Relation: __________

Emergency Contact Phone Number: __________ Family Physician: __________

Previous Optometrist: __________ Last Vision Exam: __________

Pharmacy Name: __________ Pharmacy Location: __________

Patient Race:

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White

Patient Ethnicity:

- ☐ Not Hispanic or Latino
- ☐ Hispanic or Latino

☐ I Wear Glasses ☐ I Wear Contact Lenses ☐Soft ☐ Hard Current Brand of Contacts: __________

Are the contact lenses you are currently wearing comfortable? ☐ Yes ☐ No

Payment is due in full for professional services rendered in the office at the time of the visit. Medicare patients are responsible for their deductible and 20% co-insurance that Medicare does not pay.

Patient Signature: ____________________ Date: __________

Patient Representative: ____________________ Date: __________

Medical History

Medical Allergies: ______________________________

Past Medical History: ______________________________

Past Surgical History: ______________________________

Current Medications (Name and Purpose):

____

____

____

Family History

Please note relation to yourself:

Blindness: ______________________

Cataracts: ______________________

Macular Degeneration: ______________________

Glaucoma: ______________________

Retinal Detachment: ______________________

Crossed Eyes: ______________________

Lupus: ______________________

Cancer: ______________________

Diabetes: ______________________

Heart Disease: ______________________

High Blood Pressure: ______________________

Kidney Disease: ______________________

Arthritis: ______________________

Thyroid Disease: ______________________

Other: ______________________________

☐ Please check if you are currently pregnant or nursing.

Social History

(Please Circle)

Do you use tobacco? Yes or No

Do you use illegal drugs? Yes or No

Have you ever been a smoker? Yes or No

Do you drink alcohol? Yes or No
If so, how often? ______________________

Have you ever been exposed to or infected with any of the following diseases?

Gonorrhea Hepatitis Herpes Syphilis HIV

Review of Systems

Please check all that apply to you.

***If none of these apply to you, please mark N/A and initial: ____________ Initial: ______________**

Eyes

- ☐ Vision loss
- ☐ Blurry Vision
- ☐ Distorted Vision
- ☐ Double Vision
- ☐ Dryness
- ☐ Redness
- ☐ Mucous Discharge
- ☐ Gritty Feeling
- ☐ Itching
- ☐ Burning
- ☐ Excessive Watering
- ☐ Light Sensitivity
- ☐ Eye Pain/Soreness
- ☐ Sties
- ☐ Flashes
- ☐ Floating Spots
- ☐ Tired Eyes
- ☐ Cataracts
- ☐ Diabetic Retinopathy
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Retinal Detachment

Cardiovascular

- ☐ Heart Disease
- ☐ Hypertension
- ☐ Hypercholesterolemia

Ears/ Nose/Throat

- ☐ Allergies
- ☐ Sinus Congestion
- ☐ Runny Nose
- ☐ Chronic Cough
- ☐ Dry Throat/Mouth

Allergic/Immune

- ☐ Drug Allergies
- ☐ Seasonal Allergies
- ☐ Lupus ☐ Arthritis

Lymphatic/Hematologic

- ☐ Anemia
- ☐ Bleeding Problems
- ☐ Leukemia

Musculoskeletal

- ☐ Fibromyalgia
- ☐ Muscular Dystrophy
- ☐ Osteoarthritis

Genitourinary

- ☐ Kidney Problems
- ☐ Bladder Problems

Constitutional

- ☐ Fever
- ☐ Weight Loss/Gain
- ☐ Fatigue
- ☐ Trauma

Integumentary (Skin)

- ☐ Eczema
- ☐ Rosacea
- ☐ Psoriasis

Neurological

- ☐ Headaches
- ☐ Migraines
- ☐ Seizures
- ☐ Multiple Sclerosis

Endocrine

- ☐ Non-Insulin Diabetes
- ☐ Insulin Diabetes
- ☐ Thyroid Dysfunction
- ☐ Hormonal Dysfunction
- ☐ Respiratory
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema

HIPAA Omnibus Rule

Patient Acknowledgement Form

You may refuse to sign this acknowledgement and authorization. In refusing, we may not be allowed to process insurance claims.

Advanced Eye Care abides by the Health Insurance Portability and Accountability Act (HIPAA), and this facility is bound by law to provide privacy and protect patients' medical records and other health information. Providing your signature below will serve as a phi document of release should you request treatment or radiographs be sent to other attending Doctors/facilities in the future. In addition, you are authorizing that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

______________________________ ______________________________

Print Patient's Name Sign Name (Representative or Guardian if minor)

Relationship to patient if minor: ____________________

Your comments regarding Acknowledgements or Consents: ______________________________

____

Please list any other parties who can have access to your health information:
(This includes: step parents, grandparents, and any caretakers who can have access to this patient's records):

Name: ______________________________ Relationship: _________________________

Name: ______________________________ Relationship: _________________________

I authorize contact from this office to confirm my appointments, treatment, and billing information via:

- ☐ Cell Phone Call Confirmation
- ☐ Home Phone Confirmation
- ☐ Work Phone Confirmation
- ☐ Text Message Cell Phone Confirmation
- ☐ Email Confirmation
- ☐ Any of the Above

I authorize information about my health to be conveyed via:

- ☐ Cell Phone Call Confirmation
- ☐ Home Phone Confirmation
- ☐ Work Phone Confirmation
- ☐ Text Message Cell Phone Confirmation
- ☐ Email Confirmation
- ☐ Any of the Above

I approve being contacted about special services, events, fundraising efforts, or new health info on behalf of this healthcare facility via:

- ☐ Cell Phone Call
- ☐ Home Phone
- ☐ Email
- ☐ Text Message
- ☐ Any of the above

Refraction Policy

Refraction is the process of determining the eye's refractive error or need for corrective spectacle and/or contact lenses. Essentially, it is the prescription that results from the examination. It is a vital part of an eye examination, but it is not a covered service by Medicare or most medical insurances. Our office fee for the refraction is $35, and this fee is collected in addition to the patient's copays.

Refund Policy

All exam fees are NON-REFUNDABLE. All contact lens fees are NON-REFUNDABLE.

Financial Policy

Contact your insurance company to obtain co-payment/co-insurance/deductible information and to verify that our physicians are participating, IN-NETWORK providers with your insurance.

Provide our office with correct and current insurance information on or before the date of service.

Bring all current insurance cards to every visit.

Obtain your insurance referrals and UNDERSTAND your insurance policy.

CO-PAYMENTS, CO-INSURANCE, and DEDUCTIBLES are collected at the time of service as REQUIRED by our contract with your insurance company. We ask that you understand that you will be responsible to pay for any health care services for which your health plan denies coverage.

Acknowledgement

I have read the above information and understand that the refraction is a non-covered service. I also understand that office visits and/or contact lens fittings are NOT refundable services. I accept full financial responsibility for the cost of these services, as well as any services my insurance does not cover following the insurance claim. I also understand the co-pay is separate from and not included in the refraction fee.

I understand and will abide by the Advanced Eye Care Financial Policy.

Signature: ______________________________ Date: ____________________

Patient Signature (parent or guardian for minor)

Optical Policies

Lenses will be made in accordance with recommendations of ANSI 280-1999 to meet the Doctor's prescription.

Any problems with the glasses must be reported **IN PERSON** within 30 days of glasses being picked up.

Advanced Eye Care cannot make any changes to your lenses after 30 days.

There is a one-time warranty on all glasses excluding sale frames. There is a $20 deductible that must be paid before frames will be exchanged for warranty.

If glasses are not picked up within 30 days after you have been contacted, they will be returned to the manufacturer with **NO REFUND.**

Contact lenses can only be returned if the box is unopened within 30 days of pick up. There will be a restocking fee of $15 for contacts that are returned.

Contact lenses must be picked up within 30 days after we have notified you they are here. There will be a restocking fee of $15 if the contact lenses are not picked up and have to be returned to the manufacturer.

We will be happy to adjust your glasses at no charge. However, we are **NOT** responsible for any damages to the frames or lenses.

Sorry, no refunds or exchanges on frames, unless the frame itself is found to be defective.

Anti-reflective coating, scratch coating, and polycarbonate lenses are under warranty for 1 year (depending on insurance) and covered only for normal wear and tear.

Please initial:

______ We are happy to adjust frames from outside locations for a fee of $10.00. We are not responsible if the frame should break during adjustment.

______ We will be happy to help you with issues on glasses purchased outside of Advanced Eye Care; however, there is a $20.00 fee for this service.

Signature: ______________________________ Date: ____________________

Patient Signature (parent or guardian for minor)