PATIENT REGISTRATION

DATE ACCT.NUMBER PT.NUMBER

PATIENT INFORMATION

First Name Middle Name Last Name

Birthdate Sex Marital Status Phone No. Cell Phone. E-Mail

Patient Address (Street, Route, Apt. No., Etc.) City State Zip Code

Drivers License No. Soc. Sec.No. Occupation

Employer Employer Phone No.

Employer Address

Referring Physician Whom to contact in case of Emergency (___)________ Telephone No.

INSURANCE INFORMATION

You are responsible for obtaining a referral 1 if one is required by your insurance carrier. If we are participating providers with your insurance carrier, we will file your claim for your office visit or surgery and allow 45 days for payment in full. Should payment not be received within 45 days, the balance due will become the obligation of the guarantor on the account and must be paid within 30 days. If you don't have insurance or we are not a participating provider with your insurance carrier, payment is expected today for services rendered.

Primary: ____

Insurance company/third party Group/ Contract No. Policy holder's name./relationship to patient DOB

Policy holder's employer Policy holder's address if different from patient

Secondary: ____

Insurance company/third party Group/Contact No. Policy holder's name/relationship to patient

Is your visit due to a work-related accident? Yes No Date of injury:

RESPONSIBLE PARTY

Patient Name: ____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to the name of provider of service and (or) supplier for any services furnished to me by provider of service and (or) supplier. I authorize any holder or medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any infom1ation needed to determine these benefits payable for related service.

LIFETIME AUTHORIZATION

Signature of Patient:____ Date________________

Responsible Party: ____ Date________________

MEDICAL HISTORY QUESTIONNAIRE
(Return to Technician when done)

Name ______________________________ **Date of Birth** ________________
Last First Middle Initial

Occupation: ____

How did you hear about us? O Friend O Relative O Internet O Other

O Doctor: ______________________________

Reason for Today's Visit: ____

____

Do you have any of the following issues with your eyes?:

	Yes	No		Yes	No		Yes	No
Blurred vision	O	O	Burning	O	O	Redness	O	O
Double vision	O	O	Dryness	O	O	Tearing	O	O
Foreign body feeling	O	O	Itching	O	O	Discharge	O	O

OTHER: ____

Does your vision make difficult any of the following activities?

	Yes	No		Yes	No		Yes	No
Driving at night	O	O	Reading small print	O	O	Watching TV	O	O
Driving during day	O	O	Reading street signs	O	O			

OTHER: ____

Do you have/have you ever had any of the following?

	Yes	No		Yes	No		Yes	No
Cataract	O	O	Floaters	O	O	Dry Eye	O	O
Diabetic Retinopathy	O	O	Eye Injury	O	O	Glaucoma	O	O
Macular Degeneration	O	O	Contact lens	O	O	Floaters		
Lazy/Crossed Eye	O	O	Glasses	O	O			

OTHER: ____

Please list all prior surgeries (including eye surgeries) and date of surgery:

____

____

Primary Care Physician: ____

Pharmacy Name: ____

Pharmacy Phone Number: ____

Do you give us permission to view your medication history? Yes O No O

Please list your current medications including eye drops or check none O None

____

____

____

Have you had or do you currently have:

	Yes	No		Yes	No		Yes	No
Asthma / COPD	O	O	Irregular heart beat	O	O	Thyroid	O	O
Diabetes	O	O	Shingles	O	O	Dialysis	O	O
High cholesterol	O	O	High blood pressure	O	O	Rheumatoid	O	O
Heart attack	O	O	Stroke	O	O	Sarcoidosis	O	O
Lupus	O	O	Hepatitis	O	O	Migraines	O	O

Other: ____

Are you allergic to any of the following?

O Aspirin O Penicillin O Codeine O local anesthetics O Latex O Sulfa drugs

O Other: please list ____

Do you have any of the following symptoms?

	Yes	No		Yes	No		Yes	No
Hearing problems	O	O	Trouble urinating	O	O	Trouble Breathing	O	O
Cough or wheeze	O	O	Rashes	O	O	Legs swelling	O	O
Dry throat/mouth	O	O	Poor balance	O	O	Nausea	O	O
Sinus congestion	O	O	Insomnia	O	O	Abdomen pain	O	O
Chest pain	O	O	Weight loss	O	O	Appetite change	O	O

Family & Social History

Please list any eye or medical problems in your parents, grandparents or siblings?

____

Check any of the following that you currently use? O Alcohol O Tobacco O Drugs

Date ________________ Patient Signature ____________________________

Date ________________ Doctor Signature ____________________________

PATIENT CONTACT INFORMATION SHEET

PATIENT LEGAL NAME: ____

DATE OF BIRTH: __________________________________

Any physician, staff, employee or representative of ALABAMA EYE & CATARACT CENTER, P.C. has my permission to discuss my account and medical conditions, which may include symptoms, treatments, diagnosis, test results, medications or any other type of protected health information with the following persons:

Name	Relationship	Contact Phone #

PATIENT'S SIGNATURE:____________________________DATE:_______________

OR

I DO NOT WANT ANYONE TO HAVE ACCESS TO MY PROTECTED HEALTH INFORMATION UNLESS I PROVIDE EXPLICIT AURTHORIZATION.

PATIENT SIGNATURE: _________________________DATE: ____________________

If any of this information changes, please notify us in order to properly update this form

ACKNOWLEDGEMENT RECEIPT

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was offered a copy of Alabama Eye & Cataract Center, P.C. Notice of Privacy Practices

Patient Name: ____

Signature of Patient:____

Date: ____________________________

Add any additional names below to receive medical information along with their relationship to the patient.

____

____

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Refraction Services and Fees

A refraction is the process of determining your best corrected vision and if there is a need *for corrective* eyeglasses or contact lenses. It is an essential part of the eye exam and it necessary to write a prescription for glasses or contact lenses.

A refraction is also needed for any patient that is complaining of blurred vision or has had any vision changes.

A refraction is NOT a covered service by Medicare or most medical insurance plans. These plans consider a refraction a "vision" service not a "medical" service.

We will NOT file the charge for a refraction with a health insurance unless we know that your plan covers the refraction charge.

Our office fee for a refraction is $30.00, and this fee is collected at the time of service in addition to any co-payment your plan may require. Should your plan pay us for the refraction, we will reimburse you accordingly.

We cannot file Insurance on both medical and routine vision plan for the same visit.

O I agree to pay the $30 refraction fee that my medical insurance does not cover.

O I decline to have refraction performed today.

Patient's Name {printed) Date

Patient's Signature {or legal Responsible Party) Relationship to Patient