PATIENT REGISTRATION A

Referred by: _____ Family doctor: _____

Patient Name._____ Today's Date: _____
Last First Middle

Home Address_____

City_____State_____ Zip Code_____

Home Phone_____ Cell Phone_____ E-mail address_____

Preferred method of contact: Phone_____Text_____E- mail_____ Marital Status Single Married Divorced Widowed

Social Security Number_____ Date of Birth_____ Age _____ Gender M F

Employer/Parent's Employer_____Occupation_____

Work Address_____Work Phone_____

City_____State_____Zip Code_____

Spouse name (Parent name if minor) _____Spouse/Parent Work Phone_____

Person to notify in case of emergency (other than spouse) _____

Phone number (s) _____Relationship_____

Primary Insurance Company		
ID#	Group #	Effective Date
Subscriber Name		**Relationship to Patient**
Social Security Number	Date of Birth	Employer

Secondary Insurance Company		
ID#	Group #	Effective Date
Subscriber Name		**Relationship to Patient**
Social Security Number	Date of Birth	Employer

I certify that I (or my dependent) have insurance coverage as stated above and agree to have insurance payments made directly to Alabama Eye & Cataract Center, P.C. to be applied to my account for services rendered. I understand that I am financially responsible for all charges incurred in the event that my insurance denies payment. I am aware there may be additional collection and/or attorney's fees if my account is referred for collection. For patients covered by Medicare the patient will be responsible for 20% of the Medicare allowable charges plus any deductibles, coinsurance and uncovered charges that apply.

_____ _____

Patient's signature **Today's date**

PATIENT REGISTRATION B

PHARMACY INFORMATION:

Preferred Pharmacy	Street Address	City	State	Phone #
_____	_____	_____	____	(___) _____

PHYSICIAN INFORMATION:

_____	_____	_____	____	(___) _____
Primary Care Physician	Street Address	City	State	Phone #
_____	_____	_____	____	(___) _____
Other Physician's Name & Specialty	Street Address	City	State	Phone #
_____	_____	_____	____	(___) _____
Other Physician's Name & Specialty	Street Address	City	State	Phone #

Responsible Party Information: (If not patient)

Name: _____

Mailing Address: _____

Phone #: _____ Relationship to Patient: _____

AUTHORIZATION FOR USE OF DISCLOSURE OF PROTECTED HEALTH INFORMATION:

I authorize my physician and/or administrative and clinical staff of **Alabama Eye & Cataract & Cataract Center, p.c.** to disclose general medical information and other protected health information to the following persons and/or entities listed below. If no one is listed below, protected health care information will not be disclosed except in those situations described in the Notice of Privacy Practices.

Name and relationship of person(s) who you wish to allow access: (e.g., your spouse, son, daughter, sibling, caretaker, and friend)

Name of Person or Entity: **Relationship:**

_____

_____

_____

_____

I have been provided a copy of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to read and understand and consent to use and disclosure of protected health information about myself for treatment, payment and health care operations.

_____ Signature of the Patient or Patient Representative

I have been provided a copy of the Financial Policy to read. I understand, that I, the patient or the patient's representative, am/is responsible for payment of all charges for service rendered. I also acknowledge that non-payment of my account may result in collections proceedings and dismissal from the practice.

_____ Signature of the Patient or Patient Representative

I request that payment of authorized Medicare, Medicaid and/or Commercial insurance carrier benefits be made either to me or on my behalf to the name of the provider of service and/or supplier for any services furnished to me by the provider of service and/or supplier. I authorize the release of my medical information to the Centers for Medicare and Medicaid Services and/or Commercial insurance carriers and its agents, which may be needed to determine these benefits payable for related service. LIFETIME AUTHORIZATION

_____ Signature of the Patient or Patient Representative

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.

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

0 I decline to have refraction performed today.

Patient's Name (printed) Date

Patient's Signature (or legal responsible party) Relationship to patient

ALABAMA EYE & CATARACT CENTER p.c.

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:

_____

_____

_____

ALABAMA EYE & CATARACT CENTER p.c.

PRIMARY CARE PHYSICIAN:

_____

Pharmacy Name:

_____

Pharmacy Phone Number:

_____

Patient consent to pull 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_____