PATIENT REGISTRATION

DATE:

Patient Information

First Name _____
Last Name _____
Daytime Phone _____
Mobile Phone _____
Email _____
Street Address _____
City/St/Zip _____
DOB _____
SSN _____
Employer _____

Spouse/Guardian Information

First Name _____
Last Name _____
Daytime Phone _____
Mobile Phone _____
Email _____
Street Address _____
City/St/Zip _____
DOB _____
SSN _____
Employer _____

Patient Information

Gender _____
Purpose of Visit _____

Vision Insurance Name: _____

Subscriber Name _____
Subscriber DOB _____
Subscriber SSN _____
Policy No. _____

Primary Medical Insurance Name: _____

Subscriber Name _____
Subscriber DOB _____
Subscriber SSN _____
Policy No. _____

Secondary Medical Insurance Name: _____

Subscriber Name _____
Subscriber DOB _____
Subscriber SSN _____
Policy No. _____

Financial Assignment Information

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and me. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Acknowledgment of Notice of Privacy Practices (NPP)

- ◯ Yes, I have read or had explained to me by this office the NPP & I wish to continue my care under said terms.
- ◯ No, I have not read this office's NPP but I was given the opportunity to read it and declined. I wish to continue my care under said terms.
- ◯ The NPP could not be read due to the emergent nature of the care needed.

Signature agreeing to all above terms _____ Date _____

PATIENT HISTORY

Vision History *(please check any that apply)*

- Amblyopia (lazy eye) ☐
- Blurred vision at a distance ☐
- Blurred vision at near ☐
- Burning ☐
- Double vision ☐
- Drooping eyelid(s) ☐
- Dryness ☐
- Cataracts ☐
- Floaters or spots ☐
- Glaucoma ☐
- Foreign body sensation ☐
- Halos ☐
- I experience regular headaches ☐
- I stopped wearing contact lenses ☐
- I stopped wearing glasses ☐
- Infection of eye or lid ☐
- Itching ☐
- Loss of peripheral vision ☐
- Loss of vision ☐
- Retinal Detachment ☐
- Redness ☐
- Macular Degeneration ☐
- Sensitivity to light/glare ☐
- Strabismus (crossed eye) ☐
- Tired eyes ☐
- Watery eyes ☐

Glasses History *(check all that apply)*

What glasses do you own?

- Backup pair ☐
- Bifocals ☐
- Distance ☐
- Progressive lens ☐
- Reading ☐
- Other:
- Safety glasses ☐
- Single vision ☐
- Sports glasses ☐
- Sunglasses ☐
- Trifocals ☐

How many hours per day do you spend using a computer? _____

Check any that apply

- Allergic to nickel (frames) ☐
- I do not want to wear glasses ☐
- Incorrect prescription ☐
- Need spare glasses ☐
- Need sunglasses with UV ☐
- Problems with current glasses ☐
- Problems with glare ☐
- Problems with night vision ☐

Contact Lens History *(check all that apply)*

What brand of contacts do you wear? _____

How old are your current contacts? _____

How often do you replace them? _____

What solution do you use for soaking? _____

What is your typical wearing schedule? _____

Check any that apply

- I do not want to wear contacts ☐
- Incorrect prescription ☐
- Interested in non-surgical correction ☐
- Interested in refractive laser surgery ☐
- Need spare contacts ☐
- Problems with current contacts ☐
- Would like to change my eye color ☐

Family History *(check all that apply)*

- Blindness ☐
- Diabetes ☐
- Eye turn/lazy eye ☐
- Glaucoma ☐
- Hypertension ☐
- Macular degeneration ☐

Allergies *(please list)*

- None ☐

PATIENT HISTORY

General Medical History *(please answer appropriately)*

When (approx.) was your last eye exam? _____

Primary care physician name _____

Primary care physician phone _____

Please list medications: (RX and Over the counter)

Surgeries:

Do you have any of the following?

- Arthritis ☐
- Asthma ☐
- Cancer ☐
- Diabetes ☐
- Heart disease ☐
- High cholesterol ☐
- HIV ☐
- Hypertension (high blood pressure) ☐
- Migraines/headaches ☐
- Pregnant or Nursing ☐

Other:

Referral Information

Why did you visit us?

- Referred by your doctor ☐
- Visited our website ☐
- Found us on social media ☐
- Referred directly ☐

Keep in touch

- Facebook email _____
- @Twitter _____

Questions and notes

Do you have a question? Concern? We want to know.

Patient Communication Agreement

I understand that as a part of my health care, DePoe Eye Center will need to contact me from time to time to: remind me of appointments, provide test results, give prescription instructions, or to communicate billing and insurance information.

I authorize DePoe Eye Center to contact me in the following ways (check all that apply)

__Home /Voice Mail OK __Cell Phone/Voice

I further authorize DePoe Eye Center to discuss matters relating to my care and/or financial account with the following individuals:

_____

Name/Relationship

_____

Name/Relationship

Signature on File

I request that payment of authorized insurance benefits to be made to DePoe Eye Center for any services furnished to me by my doctor. I authorize DePoe Eye Center to release my health information to my insurance and it's agents to determine benefits payable for related services. I permit a copy to be used in place of the original. I also accept responsibility for any balance for services rendered after insurance has paid its portion

.

Patient's Signature_____ Date: _____

I give DePoe Eye Center the authority to give my name, Student ID # and date of my eye health evaluation to Georgia Tech for reporting purposes only. No other information will be shared.

X_____ Patient **Initial**

Acknowledgement of Financial Policy

The total professional fee is due at the date of service. Any materials (glasses or contacts) fees are due at ordering. No materials will be ordered until all fees have been paid. We gladly accept: Visa, MasterCard, Discover, American Express, checks, cash and many flexible spending cards.

We now offer Care Credit as a method of payment, with 0% financing for balances over $200 to those that qualify.

We will bill any balance over 30 days old. Any account over 60 days old will be subject to a late fee. Full collection proceedings will be utilized for any account aging 90 days, unless prior arrangements have been made.

ALL no show appointments will be charged $35, if 24 hour notice is not given.

Patient's Signature_____Date: _____