

PATIENT REGISTRATION & MEDICAL HISTORY
ALL INFORMATION MUST BE COMPLETED BEFORE YOU CAN BE EXAMINED

Patient's Name: _____ DOB: _____ Age: _____ SS#: _____
FIRST MI LAST

Address: _____ Apt: _____ City: _____ State: _____ Zip: _____

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

Guarantor's Name: _____ DOB: _____ Relationship to Patient: _____

Guarantor's Cell Phone # (____) _____ Guarantor's SS#: _____

Guarantor's Address if Different: _____

Vision Insurance: _____ Number: _____

Medical Insurance: _____ Number: _____ Primary Physician: _____

Secondary Insurance: _____ Number: _____ Physicians
 Phone Number: (____) _____

COMPLETE AS MUCH AS POSSIBLE

I presently have or had problem(s) with: (*see the box below*) and also include when:

Problem	When	Problem	When	Problem	When
Itching		Flashing lights		Headaches	
Burning		Floaters		Night time glare	
Tearing		Vision loss		Eye Injury	
Dry eyes		Double vision		Eye Surgery	

I presently have or had the following medical condition(s): (*see box below*) indicate if a family member has the condition.

Problem	When	Who	Problem	When	Who
Allergies			Lupus		
Hay Fever			Hepatitis		
Asthma			AIDS/ HIV		
Arthritis			Crossed Eyes		
High Blood Pressure			Lazy Eye		
Heart Condition			Cataracts		
Thyroid Condition			Glaucoma		
Diabetes (type)			Macular Degeneration		
Cancer (type)			Retinal Disease		
			Other		

Females only: Are you pregnant? Y N Are you breast feeding? Y N

List ALL of the medications, vitamins and supplements that you are taking: _____

Allergies: Environmental, Medicines or Foods: _____

PLEASE COMPLETE BOTH SIDES

PATIENT REGISTRATION CONTINUED (page 2)

Date of last routine physical: _____ Do you use: _____ Alcohol, _____ Tobacco, _____ Drugs

Reason for visit: Routine exam Medical My main concern is: _____

YOUR FINANCIAL RESPONSIBILITY

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES AT TIME OF SERVICE.

IF MY ACCOUNT IS PUT INTO COLLECTIONS FOR ANY REASON, I UNDERSTAND AND AGREE TO PAY WHAT I OWE PLUS A \$100 COLLECTION FEE, PLUS 1.5% per month INTEREST, PLUS ALL ADMINISTRATIVE, COURT COSTS AND LEGAL FEES.

IF I(WE) TRY TO PASS A **BAD CHECK**, I(WE) AGREE TO PAY THE FULL AMOUNT OWED PLUS A \$100 BAD CHECK FEE IN CASH. IF I(WE) ARE TAKEN TO COURT FOR THEFT OF SERVICES AND PROSECUTED, I(WE) AGREE TO PAY ELDREDGE EYE ASSOCIATES FOR ALL SERVICES RENDERED, PLUS ALL COSTS WITH 1.5% per month INTEREST, ADMINISTRATIVE, COURT COSTS, LEGAL FEES, ETC.

Responsible Party or Patient's Signature: _____ Relationship to Patient: _____ Date: _____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

You have certain rights to privacy regarding your health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). This information will only be used to:

- Coordinate your treatment among health care providers who are involved in your treatment.
- Obtain payment from third-party payers for your health care services.
- Conduct normal health care operations such as assessment and improvement activities.

We have a complete list of Notice of Privacy Practices which would give you a more complete description and disclosures of your health information. You may ask for a free copy to keep.

Responsible Party or Patient's Signature: _____ Relationship to Patient: _____ Date: _____

Patient's
Name: _____

Insurance
Carrier: _____

Universal Advance Beneficiary Notice (UABN)

The purpose of this form is to help you make an informed choice about whether or not you want to receive our services, knowing that you might have to pay for them yourself.

From time to time some insurance carriers refuse to pay patient insurance claims for different reasons; examples: if your employer has not kept up on the premiums, or they (*the insurance carrier*) disagree with the type of service(s) to be performed.

Insurance carriers will not pay all your health care costs. The fact that your insurance carrier may not pay for a particular service(s) does not mean that you should not receive it. There may be a good reason your doctor recommended it.

I understand that my insurance carrier may refuse to pay for certain services.
I understand that you will bill me for services that I will have to pay while my insurance carrier is making its decision. If my insurance carrier does pay, you will refund to me any payments that are due me. If my insurance carrier denies payment, I agree to be personally responsible for full payment.

YES, I want to receive these services.

Signature of patient or person acting on the patient's behalf

Date

