Southern Eye Care

Patient Registration Form

PATIENT INFORMATION

Name: _____ **Age:** _____ **Today's Date:** _____

Address: _____
Street City State Zip

Date of Birth: _____ Last 4 Digits of SSN: _____ Gender: ☐ Male ☐ Female

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Email Address: _____

How did you hear about our office? ☐ Previous Patient ☐ Walmart Shopper ☐ Vision Center Next Door
☐ Website ☐ Friend/ Family _____

Race: ☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaskan Native
☐ Native Hawaiian or Other Pacific Islander ☐ Other

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Marital Status: ☐ Single ☐Married ☐Divorced ☐ Widowed ☐ Separated ☐ Minor Under 18

Occupation:_____ Employer:_____

VISION/MEDICAL INSURANCE

Please provide <u>BOTH</u> cards. If none, initial here: _____

_____
Vision Insurance

_____
Medical Insurance, If Any

_____
Medicare Supplement, If Any

_____
Policy Holder's Name

_____
Policy Holder's Date of Birth

XXX-XX- _____
Last 4 of Policy Holder's Social Security (REQUIRED)

_____
Policy Holder's Relationship to Patient

SOCIAL HISTORY

Are you pregnant or nursing? ☐ Y ☐ N Do you use cigarettes/tobacco? ☐ Y ☐ N If yes, how many packs a day? _____

Do you use alcohol? ☐ Y ☐ N Other substances? ☐ Y ☐ N

Have you ever been exposed to or infected with? **(check box for all that apply)**

Tuberculosis ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis ☐

EYE HISTORY

Reason for today's appointment: _____

Do you wear glasses? ☐ Y ☐ N **Contact Lenses?** ☐ Y ☐ N **Are you interested in Contact Lenses today?** ☐ Y ☐N

Date of Last Eye Exam: _____ Doctor: _____

Date of Last Medical Exam: _____ Doctor: _____

Are you **currently** having any problems with the following?

	Y	N		Y	N		Y	N
Sudden loss of vision	☐	☐	Redness	☐	☐	Stye or Chalazion	☐	☐
Double Vision	☐	☐	Itching	☐	☐	Flashes in vision	☐	☐
Mucous Discharge	☐	☐	Eye pain or soreness	☐	☐	Other: _____	☐	☐
Floaters in vision	☐	☐	Infection of eye or lid	☐	☐			

Have you had any **eye operations**? ☐ Y ☐ N If so, what type? _____ Date of Operation:_____

Have you been **diagnosed** with any of the following: ☐ Glaucoma ☐ Cataracts ☐ Dry Eye

☐ Other eye problems (Please list): _____

MEDICAL HISTORY

Have you or anyone in your family been diagnosed with:

Glaucoma	☐ Y	☐ N	Relation: _____
Retinal Detachment	☐ Y	☐ N	Relation: _____
Macular Degeneration	☐ Y	☐ N	Relation: _____
Other Eye Condition	☐ Y	☐ N	Relation: _____ Explain:_____
High Blood Pressure	☐ Y	☐ N	Relation: _____
Diabetes	☐ Y	☐ N	Relation: _____

Diabetes Type I or II: _____ Date of Diagnosis: _____ Last Blood Sugar: _____ Date: _____

Last Visit to Primary Care Physician: _____ Diabetes under control? ☐ Y ☐ N Last A1C: _____

Medications: _____

_____

_____

Medication Allergies: _____

Do you have any problems with any of these systems? (check box for all that apply)

Headaches ☐ Ear/Nose/Throat ☐ Heart ☐ Lung ☐ Blood Pressure ☐ Gastrointestinal ☐

Genitourinary ☐ Nervous ☐ Musculoskeletal ☐ Skin ☐ Mental ☐ Glands ☐

Allergic/Immunologic ☐ Weight Loss/Gain ☐

☐ Other illnesses : _____

FINANCIAL POLICY

We are committed to providing you with the best possible care. If you have vision and/or medical insurance, we wish to help you receive your maximum allowable benefits. To achieve this, we need your understanding of and assistance with our financial and payment policy. **Please provide both your vision and medical insurance cards to us at each visit.**

Payment for all services is due at the time services are rendered. We accept cash, or credit card (Visa, MasterCard and Discover).

Payment for services is due at the time services are rendered, except as outlined as follows. Insurance plans vary considerably, and we cannot predict or guarantee what part of our services will or will not be covered. It is the responsibility of the patient to provide accurate and timely insurance information. Inaccurate or untimely information given to the staff that results in denial or noncoverage by your insurance company results in the guarantor being responsible for payment. If your insurance carrier is not one with which we participate, you are responsible for payment in full.

While the filing of insurance claims is a courtesy that we extend to our patients, all charges not covered by your insurance company are your responsibility. Please understand that insurance policies are a contract between the policy holder and the insurance company. Our office is not a party of that contract. Every effort will be made to **estimate** your co-payments, deductibles, and covered services. We at no time guarantee what your insurance will or will not pay on each claim. We will cooperate fully with the regulations and requests of your insurance company that may assist in accurately filing your claim. Disputes or denied claims should be directed to your insurance carrier and/or employer. If your insurance company has not made payment within 30 days, we will ask you to contact your insurance company to make sure payment is expected. Ultimately, you are responsible for any unpaid balance. All patient balances that remain delinquent after 90 days, with no response to our requests for payment, may be referred to a collection agency. Should it become necessary to turn your account over to a collection agency, additional fees will be added to your balance.

Medicare, payment is required at the time of service until the New Year's deductible has been met. After that, we require co-payments or your liability to be paid at the time of service**. _____Initial**

Self Pay: You will be considered a "self pay" patient if you do not have insurance or have an insurance we do not accept. ____**Initial**

MINORS
Minors will not receive treatment without a parent or guardian present. Arrangements must be made with our office PRIOR to exam if another party will be bringing child for their appointment. **The parent or guardian accompanying a minor is responsible for co-insurance or full payment at time of service.** In case of divorce, regardless of decree, the parent bringing the child is responsible for payment. **_____ Initial**

I have read the above Financial Policy, I understand and agree to it.

Patient/Guardian Signature: _____ Date: _____

VISION VS. MEDICAL EXAM

If your routine vision exam reveals a medical condition or disease related to your eye, then your visit is **NOT COVERED** by your vision plan. Unfortunately, the doctor cannot tell if medical eye conditions exist before you are thoroughly examined. Any acute medical condition will become the priority and will be filed with your medical insurance. Medical visits often include specialist copays, and will apply to any medical visits as well as any follow up appointments. Your routine vision exam will be rescheduled after the medical condition has resolved. **Furthermore, your primary vision insurance plan cannot be billed for medical eye conditions (i.e. diabetes, glaucoma, amblyopia, strabismus, etc.). Medical conditions will be monitored and billed separately, often at a separate visit from your routine vision exam.** If your medical insurance is not one with which we participate, you will be advised of what the self-pay rate will be for your treatment.
_____ Initial

PATIENT HIPAA CONSENT FORM

I acknowledge I have been offered or received a copy of the Southern Eye Care, O.D., PLLC Notice of Privacy Practices. I understand that Southern Eye Care, O.D., PLLC is a healthcare provider and may share my information for treatment, payment, and healthcare operations. I understand if the Notice of Privacy Practices should be amended, modified or changed, I will be notified. If I have further questions regarding my privacy rights, I may contact the Privacy Officer at 919-556-1530.

Patient/Guardian Signature: _____ Date: _____