

**Eastside Eye Consultants**  
**PATIENT REGISTRATION**

Name: \_\_\_\_\_  
Last Name First Name Middle Name

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ My Occupation: \_\_\_\_\_

Home Ph. #: \_\_\_\_\_ Cell Ph. #: \_\_\_\_\_ Work Ph. #: \_\_\_\_\_

SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Email: \_\_\_\_\_

Sex:  Male  Female Marital Status:  Single  Divorced  Married  Widowed

I have previously been examined in this office.  Yes  No

**Referred By:**

<input type="checkbox"/> Doctor (location): _____	<input type="checkbox"/> The Internet
<input type="checkbox"/> Emergency Room (which one): _____	Which Web Site: _____
<input type="checkbox"/> Health South (which clinic): _____	<input type="checkbox"/> Yellow Pages
<input type="checkbox"/> Insurance Provider Listing:	<input type="checkbox"/> Our Office Brochure
<input type="checkbox"/> Family Member / Friend	<input type="checkbox"/> Hospital Referral Service
<input type="checkbox"/> Washington Academy of Eye Physicians & Surgeons	<input type="checkbox"/> Other: _____

My Family Physician is (location, phone #, or address if possible):  
\_\_\_\_\_

**Emergency Contacts:**

Spouse's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Parent's Name (if single or under 18): \_\_\_\_\_ Phone #: \_\_\_\_\_

"Other" Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Who is responsible for your medical bills?  Self  Spouse  Father  Mother  Other: \_\_\_\_\_

Responsible Party's Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Address: \_\_\_\_\_

Does your medical insurance cover eye problems?  Yes  No  Uncertain

Does your medical insurance cover glasses and contact measurements?  Yes  No  Uncertain

If you are uncertain whether or not your insurance covers today's visit, please notify the receptionist.

Are you required to make an insurance co-payment?  Yes  No  Uncertain, If Yes, how much? \_\_\_\_\_

On the Job Accident?  Yes  No  N/A

Claim #: \_\_\_\_\_ Accident Date: \_\_\_\_\_ Claim Now Open?  Yes  No

**Insurance with:** 1) \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Subscriber Date of Birth: \_\_\_\_\_

2) \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Subscriber Date of Birth: \_\_\_\_\_

I confirm this information to be true and I authorize the release of any medical information necessary to process this claim. I am financially responsible for any balance due. I authorize the release of payment for medical benefits to my doctor.

Patient's or Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PLEASE TURN OVER** 

# Medical History

## Please indicate what you would like to be provided today:

- Annual comprehensive eye examination       Consultation at my referring doctor's request  
 Evaluation for vision correction procedures to avoid glasses or contacts       Second Opinion  
 Other: (I am concerned about – which eye(s) or eyelid(s)) \_\_\_\_\_
- 

## Contact Lens Review (Please indicate all that apply):

- I prefer not wearing contact lenses (If so, please skip down to **Past Medical History** below).  
 My current contacts seem fine, and I am happy with them as they are.  
 When were your current lenses prescribed? R \_\_\_\_\_ L \_\_\_\_\_  
Fitted by (Name, Location): \_\_\_\_\_ Brand Name of Contacts: \_\_\_\_\_  
 I would like to be evaluated and fitted in contact lenses for the first time.  
 I would like to purchase contact lenses from you  
 As a new or established wearer: I would like a contact lens fitting and evaluation understanding that in order to determine lens suitability / in-suitability or determine an appropriate contact lens prescription, an analysis of the shape (diameter, vault) fit (looseness or tightness) and power (nearsightedness, farsightedness, or astigmatism correction) of each contact lens is required. This can be done at the same time as complete eye examination and refraction, but require a separate fee, analysis, and prescription different from eyeglass measurements.  
 Does your insurance plan help to cover the cost of contact lenses?  Yes  No  Uncertain  
 I would like to be fitted with cosmetic contact lenses to enhance or alter my eye color.

**N.B.** We can not provide contact lens fitting information to outside facilities unless the initial contact lens fitting is performed here.

## Past Medical History:

List all medication that makes you sick or that you are allergic to ( None): \_\_\_\_\_

List all eye drops that you are currently administering ( None): \_\_\_\_\_

List all medications that you are currently administering except eye drops: ( None): \_\_\_\_\_

List all operations that you have had on any part of your body, including your eyes ( None): \_\_\_\_\_

## Please indicate whether you have ever had problems with the following:

- |   |                                       |  |                                       |                                       |
|---|---------------------------------------|--|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Heart          | <input type="checkbox"/> Diabetes     | <input type="checkbox"/> Brain               | <input type="checkbox"/> Intestine    | <input type="checkbox"/> Crossed Eyes |
| <input type="checkbox"/> Lungs          | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Cancer              | <input type="checkbox"/> Acne Rosacea | <input type="checkbox"/> Lazy Eye     |
| <input type="checkbox"/> Liver          | <input type="checkbox"/> Stroke       | <input type="checkbox"/> Prism in my glasses | <input type="checkbox"/> Dry Eyes     | <input type="checkbox"/> Eye Trauma   |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Thyroid      | <input type="checkbox"/> Skin                |                                       |                                       |

I have not had problems with the items mentioned above.

Other? \_\_\_\_\_

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Which blood relatives have:  Cataracts, who? \_\_\_\_\_  No one  
 Glaucoma, who? \_\_\_\_\_  No one  
 Retinal Detachment, who? \_\_\_\_\_  No one  
 Macular Degeneration, who? \_\_\_\_\_  No one

Smoking?  Yes  No  Never      Alcohol Intake?  None  Occasional Wine/Beer  Other

Do you currently wear eyeglasses of any kind?  Yes  No

How well are your current eyeglasses working?  No complains  Need an update

Date of last exam: \_\_\_\_\_

In the exam rooms, please have your eyeglasses, prior contact lens, and eyeglass prescriptions available for inspection if they might require updating. Thank you!

# Eastside Eye Consultants

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physicians certifications

I have received, read and understand your **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its **Notice of Privacy Practices** from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the **Notice of Private Practices**.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patients Name (Please Print) \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

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**APPOINTMENT REMINDER CALL AUTHORIZATION**

May we leave messages at this number:

HOME PHONE #: \_\_\_\_\_ Yes  No

CELL PHONE #: \_\_\_\_\_ Yes  No

WORK PHONE #: \_\_\_\_\_ Yes  No

Please list names of persons other than yourself that we may discuss your medical care with (if any):

\_\_\_\_\_  
\_\_\_\_\_

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**OFFICE USE ONLY**

Signed Yes  No  Reason: \_\_\_\_\_

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**Medicare Patients Only**

Medicare will only pay for services that it determines to be "reasonable and necessary" under Section 1862 (a) (1) of the Medicare Law. If Medicare determines that a particular service, although it would otherwise be covered, is "not reasonable and necessary" under the Medicare program standard, Medicare will deny payment for that service.

I believe in your case, Medicare is likely to deny payment for REFRACTION (measurements for glasses and contact lenses) for the following reason: Refraction is not a covered service.

**Beneficiary Agreement:**

I have been notified by my physician/supplier that he or she believe that, in my case, Medicare is likely to deny payment for the services identified above, for the reasons stated. If Medicare denies payment, I agree to be personally and fully responsible for payment.

Signed: \_\_\_\_\_ Dated: \_\_\_\_\_