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:

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

__ Heart	__ Diabetes	__ Brain	__ Intestine	__ Crossed Eyes
__ Lungs	__ Hypertension	__ Cancer	__ Acne Rosacea	__ Lazy Eye
__ Liver	__ Stroke	__ Prism in my glasses	__ Dry Eyes	__ Eye Trauma
__ Kidney Disease	__ Thyroid	__ Skin		

__ I have not had problems with the items mentioned above.
Other? _____
_____

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 _____

☐ **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):

_____

_____

OFFICE USE ONLY

Signed Yes ☐ No ☐ Reason: _____

☐ 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: _____