Rev 12/10

Cortland Eye Center

PATIENT REGISTRATION FORM

Today's Date: _____ Dr ☐ Rev ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐

_____
First Initial Last

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: ( ) Work Phone: ( ) Cell Phone: ( )

Race: White American Indian/Alaska Native African-American Asian Native Hawaiian/Other Pacific Islander

Ethnicity: Spanish/Hispanic Origin Not of Spanish/Hispanic Origin Declined/Unknown

Marital Status: Single Married Divorced Widowed Legally Separated

Sex: M F Date of Birth: ____/____ /____ Age: _____

Referred by: _____ Primary Physician: _____

Retired: Y N Retirement Date: _____ Pharmacy: _____ Location: _____

Employer: _____ Employer Phone: _____

City: _____ State: _____ Zip: _____ Occupation: _____

Emergency Contact Name: _____ Phone: _____ Relationship: _____

Insurance Information: Please list the subscriber of the policy if other than the patient.

Primary: _____ Policy #: _____

Insurance Address: _____ Group #: _____

Subscriber: _____ Plan Name: _____

Date of Birth: _____ Co-pay Amt: _____

Social Security #: _____ Relationship: _____

Secondary: _____ Policy #: _____

Insurance Address: _____ Group #: _____

Subscriber: _____ Plan Name: _____

Date of Birth: _____ Co-pay Amt: _____

Social Security #: _____ Relationship: _____

Send Bill to: Patient Employer Other/Relationship _____

Address: _____ Phone #: ( ) _____

City: _____ State: _____ Zip: _____

If responsible party is other than patient-

Date of Birth: _____ SS#: _____ Employer: _____

****see back of form for Authorizations & Agreements***

Ver 06/2016

Signature On File/Assignment of Benefits/Financial Agreement

_____

Name *(Print)*

1. MEDICARE LIFETIME ASSIGNMENT/SIGNATURE ON FILE: I request that payment of authorized Medicare benefits be made on my behalf to Cortland Eye Center (CEC), for services furnished to me by CEC. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. CEC accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

2. MEDIGAP: I understand that if a Medigap policy of other health insurance is indicated in item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to CEC, if possible, otherwise to me.

3. NOTICY OF PRIVACY PRACTICES: Notice of Privacy Practices has been provided.

4. OTHER INSURANCE: I understand that CEC maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office. I understand that CEC has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by CEC if I belong to a plan that does not appear on the above mentioned list.

5. NON-COVERED SERVICES: I understand that CEC's contracts with health care service plans (i.e., HMOs, PPOs) relate only to items and services that are "covered" by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services that are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health service plan or in the benefit summary the health care service plan furnishes to the patient; and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with CEC to obtain all necessary health care service plan authorizations.

6. FINANCIAL AGREEMENT: I agree that in return for the services provided to the patient by CEC, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to CEC for payment. If my account is delinquent and requires collection services, I agree to pay all collection expenses, attorney fees, and/or court costs. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, and any other party liable to the patient, is hereby assigned to CEC. I understand and agree that any unmet deductibles are my responsibility. **I understand and agree that my insurance co-pay is due at the time of service and if not paid to CEC at the time of service, I will be charged and agree to pay a $15.00 billing fee. I also understand that there will be a service fee applied for all payments I make that are not honored by my banking or credit/debit card institution** (bounced checks, etc.)**.**

7. TERM OF AUTHORIZATION: This authorization shall remain in effect until I choose to revoke it.

_____ _____

Beneficiary Signature Patient or Authorized Party Date

Note: Must Be Signed To Bill <u>All</u> Insurance Companies

Rev 01/27/11

Cortland Eye Center

PATIENT HISTORY RECORD

Name:_____ Age:_____ Date: _____

Drug or food allergies?
Yes ☐ No ☐ If YES, please list:_____

Have you ever been treated for any medical conditions (such as diabetes, high blood pressure, arthritis, etc.)**?**
Yes ☐ No ☐ If YES, explain: _____

Have you had any eye disease/eye injuries/eye surgery (such as glaucoma, cataract, "lazy" eye, retinal detachment, etc.)**?**
Yes ☐ No ☐ If YES, explain: _____

_____

Have you ever had any other surgery? Yes☐ No☐ If YES, provide date & procedure: _____

_____

_____

Do you use any eye medications?
Yes ☐ No ☐ If YES, please list: _____ _____

_____ _____

Do you take any other medications?
Yes ☐ No ☐ If YES, please list: _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Review of Systems

*Do you **currently** have any of the following problems:*	Yes	No	If Yes, please explain:
Eyes (poor vision, eye pain, tearing, dry eye, redness, etc)	☐	☐	_____
Constitutional (Chronic fever, unexpected weight loss/gain, fatigue)	☐	☐	_____
Ear/nose/throat problems(hearing loss, sinus problems, sore throat, etc)	☐	☐	_____
Cardiovascular/Heart problems(high BP,chest pain, irreg. heart beat,etc)	☐	☐	_____
Respiratory problems (shortness of breath, wheezing, cough, etc)	☐	☐	_____
GI problems (heartburn, abdominal pain, diarrhea, vomiting,hernia, ulcers,etc.)	☐	☐	_____
Urinary/Kidney/Bladder problems (pain, discomfort, blood in urine, etc)	☐	☐	_____
Females (Are you pregnant? Nursing?)	☐	☐	_____
Musculoskeletal (Muscle aches, joint pain, swollen joints, arthritis)	☐	☐	_____
Skin Problems (rashes, excessive dryness, growths,etc)	☐	☐	_____
Neurological (numbness, weakness, headaches, seizures, paralysis)	☐	☐	_____
Psychiatric problems (depression, anxiety, insomnia, etc)	☐	☐	_____
Endocrine problems (Diabetes, thyroid problems, etc.)	☐	☐	_____
Blood/Lymphatic problems (anemia, leukemia, bleeding tendencies, swollen glands, etc.)	☐	☐	_____
Allergic/Immunologic problems (lupus, severe allergies, HIV, immunosuppressed etc)	☐	☐	_____

Family & Social History: (Blood relatives only – Mother, Father, Grandparent, Sibling)
Circle any conditions that run in your family: *Diabetes, High Blood Pressure, Blindness, Glaucoma, Macular Degeneration, Crossed/Lazy eye(s), Thyroid Disease, Other eye disease/conditions:*_____
Who?_____

☐Never Smoked ☐Occasionally Smokes ☐Quit ☐Current Smoker x ___ Years How much? _____

☐No Alcohol Consumption ☐ Yes Drinks Alcohol? How much?_____

PLEASE COMPLETE REVERSE SIDE ALSO

Name: _____ **Date:** _____

In order to serve your eye care needs: **Are you having any of the following eye problems or symptoms?**

	Yes	No	Explanation of Problem
Loss of vision or blurred vision	☐	☐	……
Flashes and/or floaters	☐	☐	……
Distorted vision (halos)	☐	☐	……
Loss of side vision (peripheral)	☐	☐	……
Double vision	☐	☐	……
Dryness of eyes	☐	☐	……
Mucous discharge of eyes	☐	☐	……
Redness	☐	☐	……
Sandy or gritty feeling	☐	☐	……
Itching and/or burning sensation	☐	☐	……
Foreign body sensation	☐	☐	……
Excessive tearing/watering	☐	☐	……
Glare/Light sensitivity	☐	☐	……
Eye pain or soreness	☐	☐	……
Chronic infection of eye or lid	☐	☐	……
Sties, Chalazion	☐	☐	……
Fluctuating vision acuity (vision)	☐	☐	……
Problems with night vision or driving	☐	☐	……

To assist us in appropriately prescribing and fitting your eyewear, please check the proper responses:

Work environment: ☐**office setting** ☐**fluorescent lighting** ☐**industrial setting/construction work**

Computer use: **Hours/day spent on computer at work** _____ **at home use** _____

Driving: ☐ **day** ☐**night** ☐**bothered by brightness/glare** ☐**bothered by headlights or halos**

Hobbies: ☐**needlework/sewing** ☐**musician** ☐**pilot/shooter/marksman** ☐**avid reader**
☐**stamp/coin collector, etc.** ☐**woodworking** ☐**gardening** ☐**other** _____

Sports: ☐**golf** ☐**racquet sports** ☐**skiing** ☐**fishing/hunting** ☐**other** _____

☐ **use more than 1 pair glasses** ☐**happy with current glasses** ☐**problems with current glasses**

FOR OFFICE USE ONLY

Changes + Updates to this information are noted on the exam notes.

Updated: _____ _____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____ _____