WEST EYE ASSOCIATES

PATIENT REGISTRATION FORM

WELCOME TO OUR OFFICE! This form will aid us in ensuring that we submit your claim to your insurance company promply and accurately. If your plan requires a referral, please provide it to the receptionist or advise us so that we may check to be sure we received it. THANK YOU.

Payment for services or co-pay is expected at time of service.

PATIENT'S NAME FIRST M.I. LAST	DATE OF BIRTH	M F OTHER ☐ ☐ ☐	SOCIAL SECURITY NUMBER
RESPONSIBLE PARTY (IF A MINOR)			
STREET ADDRESS	CITY AND STATE ZIP CODE	MARITAL STATUS S M W D SEP	
MAILING ADDRESS (ID DIFFERENT FROM ABOVE)	CITY AND STATE ZIP CODE	HOME PHONE NUMBER	
EMAIL ADDRESS ☐ CONSENT TO RECEIVE ELECTRONIC COMMUNICATION		CELL PHONE ☐ CONSENT TO RECEIVE ELECTRONIC COMMUNICATION	
IN CASE OF AN EMERGENCY WHO SHOULD WE NOTIFY?	RELATIONSHIP	PHONE NUMBER	

Insurance: Please list the subscriber of the policy if other than the patient. List your primary insurance first.

PRIMARY_____ **Policy #** _____ **Group #** _____

Subscriber _____ **Subscriber's Date of Birth** _____

Subscriber's Employer _____

SECONDARY_____ **Policy #** _____ **Group #** _____

Subscriber _____ **Subscriber's Date of Birth** _____

Subscriber's Employer _____

NOTICE OF PRIVACY PRACTICES

Our goal is to take appropriate steps to attempt to safeguard any medical or other personal information that is provided to us. The Privacy Rule under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires us to: (i) maintain the privacy of medical information provided to us; (ii) provide notice of our legal duties and privacy practices; and (iii) abide by the terms of our Notice of Privacy Practices currently in effect.

Our notice of Privacy Practice is always available on our website: https://westeyeguy.wixsite.com/westeyeassociates, posted in our office, or an original from the front desk upon request.

Signature: _____ **Date:** _____

HEALTH HISTORY

NAME (FIRST MI LAST)	TITLE/NICKNAME	TODAY'S DATE
DATE OF BIRTH	AGE	OCCUPATION

GENERAL INFORMATION

CURRENT PRIMARY CARE PHYSICIAN _____

LAST VISIT? _____

ARE YOU CURRENTLY PREGNANT OR NURSING? □YES □NO

DO YOU CURRENTLY USE TOBACCO PRODUCTS? □YES □NO

IF YES, HOW MUCH/HOW OFTEN: _____

DO YOU CURRENTLY DRINK ALCOHOL? □YES □NO

IF YES, HOW MUCH/HOW OFTEN: _____

CURRENT MEDICATIONS

NAME	DOSAGE	HOW OFTEN	ADMINISTRATION (ORAL, INJECTION, ETC.)

DO YOU HAVE ANY MEDICATION ALLERGIES? □YES □NO

IF YES, PLEASE NOTE MEDIATION AND REACTION: _____

_____

SURGICAL HISTORY

OCULAR SURGERIES (APPROX. DATE): _____

_____

OTHER SURGERIES (APPROX. DATE): _____

_____

OCULAR HISTORY

CHECK ANY OF THE FOLLOWING THAT APPLY AND THE APPROX. YEAR IF APPLICABLE

SERIOUS EYE INJURY		YEAR	RETINAL DETACHMENT		YEAR
EYE TURN/ LAZY EYE			DIABETIC EYE PROBLEMS		
GLAUCOMA			MACULAR DEGNERATION		
CATARACTS			DRY EYE		
OTHER:					

FAMILY HISTORY

INDICATE ANY BLOOD RELATIVE(S) WHO HAVE HAD THE FOLLOWING

CONDITION	RELATIVE	CONDITION	RELATIVE
GLAUCOMA		DIABETES	
MACULAR DEGENERATION		HIGH BLOOD PRESSURE	
RETINAL DETACHMENT		HEART ATTACK	
CATARACTS		STROKE	
BLINDNESS		CANCER	
OTHER:			

MEDICAL HISTORY

CHECK AND NOTE APPROX. YEAR ANY OF THE FOLLOWING CONDITIONS YOU HAVE

DIABETES		YEAR	HEART ATTACK		YEAR
HIGH BLOOD PRESSURE			STROKE		
HIGH CHOLESTEROL			CANCER		
ASTHMA			CANCER TYPE:		
THYROID CONDITION			NEUROLOGICAL/HEADACHES		
HEART DISEASE			IMMUNE CONDITIONS		
OTHER:					

COMMENTS: _____

PATIENT SIGNATURE_____DATE _____

PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing West Eye Associates as your eye care provider. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

- You are responsible for the payment of your treatment and care.
- If the patient is a minor, then as the patient's guardian you are ultimately responsible for payment of the minor's treatment and care, even if you are not the carrier of your child's insurance policy.
- If you have insurance, we will bill your insurance for you. However, for every visit, you are required to provide correct and updated information regarding insurance.
- You are responsible for payment of:
    - Co-payments
    - Co-insurance
    - Deductibles
    - All other procedures or treatments not covered by your insurance plan.
- Co-payments are due at the time of service.
- Co-insurance, deductible and non-covered items are due within 30 days from receipt of billing.
- If you do not have insurance, you are responsible for payment and your treatment of care on date of service.
- If you are here for a Worker's Compensation visit, you must provide appropriate employer and billing information for use to process the claim. Without this information, we will consider payment for the visit to be your responsibility.
- You man incur, and are responsible for payment of additional charges, if applicable. These charges may include:
    - Charge for returned checks

By my signature below, I hereby acknowledge that I understand that I am responsible for full payment (less any adjustments West Eye Associates are contractually required to make) within 30 days of receipt of my statement. I understand that I am financially responsible for charges not covered by my insurance.

I have read, understand and agree to the provisions of the Patient Responsibility Form.

_____ _____

Name of Patient (please print) Date of Birth

_____ _____

Signature of patient or guardian Date

West Eye Associates

Authorization to Provide Services

Reason for today's visit *(check all that apply- fees vary according to level of service):*

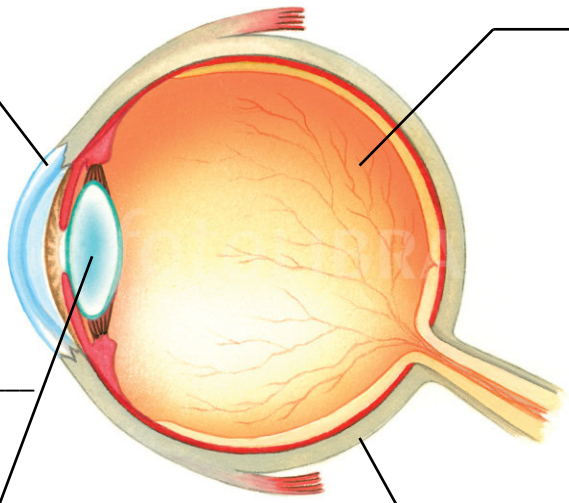
☐**MEDICAL EYE EXAMINATION** for medical eye problems, including new and/or known conditions, or annual diabetic exam. (Billable to medical insurance)

*Eyeglasses and/or contacts can be evaluated for a fee

*Although refraction is a vital test in the care of your eyes, it is a **non-covered** benefit with most medical insurances/Medicare. We are required to charge for this service. There is a **$40.00** fee for this test. You will be asked to pay at the time of your visit. This is a routine charge at all medical, optometric, and surgical ophthalmology and optometry practices.

_____ I understand that refraction is a non-covered service and that I am responsible for
Initials the fee if I request an updated prescription.

Please check any of the medical problems below that you would like evaluated:



Exterior

Discomfort

- ☐ Dryness
- ☐ Burning
- ☐ Itching
- ☐ Watering
- ☐ Eyelid Problems
- ☐ Other: _____

Interior

Issues

- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Cataracts
- ☐ Diabetic Retinopathy
- ☐ Other: _____

Vision

Disturbance

- ☐ Flashes/Floaters
- ☐ Blurry
- ☐ Cloudy/Film
- ☐ Loss of Vision
- ☐ Double Vision
- ☐ Other: _____

General

Health

- ☐ Diabetes
- ☐ Plaquenil Use
- ☐ Headaches
- ☐ Other: _____

☐**PREVENTITIVE CARE EVALUTION/VISION CARE EXAMINATION** for vision needs including prescription measurements (eyeglasses and/or contact lenses) and eye health screening. No known medical eye problems. (Billable to Vision Care Plan)

I authorize the above services and agree to pay my appropriate co-pays, deductibles, and allowable fees for services rendered.

Name (Printed)	Signature	Date