

PATIENT REGISTRATION

DATE: _____

Patient Information

First Name	_____	Street Address	_____
Last Name	_____	City/St/Zip	_____
Daytime Phone	_____	DOB	_____
Mobile Phone	_____	SSN	_____
Email	_____	Employer	_____

Spouse/Guardian Information

First Name	_____	Street Address	_____
Last Name	_____	City/St/Zip	_____
Daytime Phone	_____	DOB	_____
Mobile Phone	_____	SSN	_____
Email	_____	Employer	_____

Patient Information

Gender _____
Purpose of Visit _____

Vision Insurance Name: _____

Subscriber Name _____
Subscriber DOB _____
Subscriber SSN _____
Policy No. _____

Primary Medical Insurance Name: _____

Subscriber Name _____
Subscriber DOB _____
Subscriber SSN _____
Policy No. _____

Secondary Medical Insurance Name: _____

Subscriber Name _____
Subscriber DOB _____
Subscriber SSN _____
Policy No. _____

Financial Assignment Information

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and me. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Acknowledgment of Notice of Privacy Practices (NPP)

- Yes, I have read or had explained to me by this office the NPP & I wish to continue my care under said terms.
- No, I have not read this office's NPP but I was given the opportunity to read it and declined. I wish to continue my care under said terms.
- The NPP could not be read due to the emergent nature of the care needed.

Signature agreeing to all above terms _____ Date _____

PATIENT HISTORY

Vision History (please check any that apply)

Amblyopia (lazy eye) <input type="checkbox"/>	Glaucoma <input type="checkbox"/>	Loss of vision <input type="checkbox"/>
Blurred vision at a distance <input type="checkbox"/>	Foreign body sensation <input type="checkbox"/>	Retinal Detachment <input type="checkbox"/>
Blurred vision at near <input type="checkbox"/>	Halos <input type="checkbox"/>	Redness <input type="checkbox"/>
Burning <input type="checkbox"/>	I experience regular headaches <input type="checkbox"/>	Macular Degeneration <input type="checkbox"/>
Double vision <input type="checkbox"/>	I stopped wearing contact lenses <input type="checkbox"/>	Sensitivity to light/glare <input type="checkbox"/>
Drooping eyelid(s) <input type="checkbox"/>	I stopped wearing glasses <input type="checkbox"/>	Strabismus (crossed eye) <input type="checkbox"/>
Dryness <input type="checkbox"/>	Infection of eye or lid <input type="checkbox"/>	Tired eyes <input type="checkbox"/>
Cataracts <input type="checkbox"/>	Itching <input type="checkbox"/>	Watery eyes <input type="checkbox"/>
Floater or spots <input type="checkbox"/>	Loss of peripheral vision <input type="checkbox"/>	

Glasses History (check all that apply)

What glasses do you own?

Back up pair <input type="checkbox"/>	Safety glasses <input type="checkbox"/>	Check any that apply
Bifocals <input type="checkbox"/>	Single vision <input type="checkbox"/>	Allergic to nickel (frames) <input type="checkbox"/>
Distance <input type="checkbox"/>	Sports glasses <input type="checkbox"/>	I do not want to wear glasses <input type="checkbox"/>
Progressive lens <input type="checkbox"/>	Sunglasses <input type="checkbox"/>	Incorrect prescription <input type="checkbox"/>
Reading <input type="checkbox"/>	Trifocals <input type="checkbox"/>	Need spare glasses <input type="checkbox"/>
Other: _____		Need sunglasses with UV <input type="checkbox"/>
		Problems with current glasses <input type="checkbox"/>
		Problems with glare <input type="checkbox"/>
		Problems with night vision <input type="checkbox"/>

How many hours per day do you spend using a computer? _____

Contact Lens History (check all that apply)

What brand of contacts do you wear? _____	Check any that apply
How old are your current contacts? _____	I do not want to wear contacts <input type="checkbox"/>
How often do you replace them? _____	Incorrect prescription <input type="checkbox"/>
What solution do you use for soaking? _____	Interested in non-surgical correction <input type="checkbox"/>
What is your typical wearing schedule? _____	Interested in refractive laser surgery <input type="checkbox"/>
	Need spare contacts <input type="checkbox"/>
	Problems with current contacts <input type="checkbox"/>
	Would like to change my eye color <input type="checkbox"/>

Family History (check all that apply)

Blindness <input type="checkbox"/>	Hypertension <input type="checkbox"/>	Allergies (please list) <input type="checkbox"/>
Diabetes <input type="checkbox"/>	Macular degeneration <input type="checkbox"/>	None <input type="checkbox"/>
Eye turn/lazy eye <input type="checkbox"/>		
Glaucoma <input type="checkbox"/>		

PATIENT HISTORY

General Medical History *(please answer appropriately)*

When (approx.) was your last eye exam? _____

Primary care physician name _____

Primary care physician phone _____

Please list medications: (RX and Over the counter)

Surgeries:

Do you have any of the following?

Arthritis

Asthma

Cancer

Diabetes

Heart disease

High cholesterol

HIV

Hypertension (high blood pressure)

Migraines/headaches

Pregnant or Nursing

Other:

Referral Information

Why did you visit us?

Referred by your doctor

Found us on social media

Keep in touch

Facebook email _____

Visited our website

Referred directly

@Twitter _____

Questions and notes

Do you have a question? Concern? We want to know.

Patient Communication Agreement

I understand that as a part of my health care, DePoe Eye Center will need to contact me from time to time to: remind me of appointments, provide test results, give prescription instructions, or to communicate billing and insurance information.

I authorize DePoe Eye Center to contact me in the following ways (check all that apply)

Home /Voice Mail OK Cell Phone/Voice

I further authorize DePoe Eye Center to discuss matters relating to my care and/or financial account with the following individuals:

Name/Relationship

Name/Relationship

Signature on File

I request that payment of authorized insurance benefits to be made to DePoe Eye Center for any services furnished to me by my doctor. I authorize DePoe Eye Center to release my health information to my insurance and it's agents to determine benefits payable for related services. I permit a copy to be used in place of the original. I also accept responsibility for any balance for services rendered after insurance has paid its portion

Patient's Signature _____ Date: _____

I give DePoe Eye Center the authority to give my name, Student ID # and date of my eye health evaluation to Georgia Tech for reporting purposes only. No other information will be shared.

_____ Patient Initial

Acknowledgement of Financial Policy

The total professional fee is due at the date of service. Any materials (glasses or contacts) fees are due at ordering. No materials will be ordered until all fees have been paid. We gladly accept: Visa, MasterCard, Discover, American Express, checks, cash and many flexible spending cards.

We now offer Care Credit as a method of payment, with 0% financing for balances over \$200 to those that qualify.

We will bill any balance over 30 days old. Any account over 60 days old will be subject to a late fee. Full collection proceedings will be utilized for any account aging 90 days, unless prior arrangements have been made.

ALL no show appointments will be charged \$35, if 24 hour notice is not given.

Patient's Signature _____ Date: _____