Precision Eye Consultants

Patient Registration Form

PATIENT INFORMATION

Patient's Name: ______________________________ Date of Birth: ________________

Address: ____ Age: __________

City: _________________________ State: ______________ Zip: _______________

Home Phone: ______________ Work #: _______________ Social Sec. #: ____________

Female: ___ Male: ___ Email: ____

Marital Status: Child Single Married Divorced Widowed

Ethnicity: ____________ Race: ____________ Preferred language: __________________

Employer: _________________________________ Phone: ______________________

Employer Address: ____

Employer City: _________________________ State: _________ Zip: ______________

IN CASE OF EMERGENCY NOTIFY: Name: ___________ Number: _________ Relationship: _________

Referred to Us By: ____

Primary Care Physician: _______________________ Phone: _______________________

INSURANCE INFORMATION

Main Policy Holder:(if different than the patient): ___________________________________

Relationship to Patient: ______________ DOB: ___________ Social: __________________

CONSENT FOR TREATMENT

Intials:_______I hereby give my consent to my physician and/or his designated healthcare specialist for the evaluation, diagnostics, testing, and treatment. I understand that I may request and receive information on the specific affiliation(s) of any particular healthcare provider I encounter during my care. I give this consent for this treatment. I understand that my visit may require dilation. I understand I am to use caution when driving while the pupils are dilated. Disposable sun shades will be given upon request.

FINANCIAL AGREEMENT

Initials:________ I hereby give permission for any treatment and care conducted by Precision Eye Consultants to share information with the patient's insurance company for the expenses incurred, as well as any third party that may be involved for the billing. I understand that the office only bills MEDICAL insurance and not vision. I agree to pay my copay upon request and it is ultimately my responsibility to check insurance benefits. I agree to pay Precision Eye Consultants any outstanding balance after my visit is billed to insurance.

PATIENT SIGNATURE:_______________________________ DATE:___________________

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon the execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

____

____

____

____

This consent was signed by: ______________________________
(PRINT NAME PLEASE)

Signature: ______________________________ Date: ____________

Witness: ______________________________ Date: ____________

Refraction
Precision Eye Consultants

PATIENT NAME: ____

A. Patient Visit Type:

- **Refraction:**
  Refraction is the optical determination of the best possible eye vision. It is needed to determine if any medical, optical, or surgical treatment may be indicated. It is NOT a covered service by most insurance plans. **Our office fee for refraction is** $__60___ and it is collected at the time of service and is in addition to any co-payment. Should your plan cover this service, you will be refunded. Please note this is a glasses prescription and NOT to be used to get contact lenses.

_______________________________ Patient Signature

_______________________________ Date

C. Refraction Notice to Patients

Refraction must be performed in order to obtain a prescription. Do you want to receive an eyeglass prescription today?

☐ Yes ☐ No **Patient's initials:** _________

Eye Questionnaire

PATIENT NAME:______________________________ DATE:__________________

Reason for your visit today:____
Do you wear glasses or contacts? **Yes** **No** -- If yes, when was your last prescription? ____________________

Do you have a current eye care provider who performs annual exams? **Yes** or **No** (Circle) (If "yes" please list the name of your provider or practice below and the date of your last visit)

____

Have you been diagnosed or treated for any of the following eye conditions?

Cataracts	Yes	No
Glaucoma	Yes	No
Diabetic eye disease	Yes	No
Macular Degeneration	Yes	No

Have you been diagnosed with or treated for any eye conditions other than those listed above? If so, please list here:____

Have you had any major surgeries? If so, please list below:

Surgery: Date:	Surgery: Date:
Surgery: Date:	Surgery: Date:

Have you had any of the eye surgeries or procedures listed below?

Cataract Surgery	Yes	No
LASIK/PRK	Yes	No
Radial Keratotomy	Yes	No
Eye Injections (for diabetes or macular degeneration)	Yes	No
Glaucoma Surgery	Yes	No

Does anyone in your family have the following eye conditions?

Glaucoma	Yes	No	Mother, Father, Sister, Brother
Diabetes	Yes	No	Mother, Father, Sister, Brother
Macular Degeneration	Yes	No	Mother, Father, Sister, Brother
Retinal Detachment	Yes	No	Mother, Father, Sister, Brother

Systemic Health Questionnaire

PATIENT NAME:______________________________ DATE:__________________

Please list the name and location of your pharmacy:

____

Do you? Smoke cigarettes (yes, no) Abuse Alcohol (yes, no) Use Drugs (yes, no)

Do you have any of the following health conditions?

	Yes	No
Diabetes		
Hypertension (high blood pressure)		
High cholesterol		
Thyroid Disease		
Atrial Fibrillation		

Do you have any health conditions other than those listed above?

Please list any medications that you may be allergic to below:

Please list any medications that are prescribed to you below:

Medication	Dose	What do you take this for?