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PATIENT REGISTRATION

Patient Name _____ Todays Date _____
Last First Middle

Home Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____

E-mail address _____ Marital Status Single Married Divorced Widowed

Social Security Number _____ Date of Birth _____ Age _____ Gender M F

Employer/Parent's Employer _____ Occupation _____

Person to notify in case of emergency (other than spouse) _____

Phone number (s) _____ Relationship _____

PHARMACY INFORMATION: (PREFERRED PHARMACY):		
Street	City, State	Phone#

Primary Insurance Company		
ID#	Group #	Effective Date
Subscriber Name		**Relationship to Patient**
Social Security Number	Date of Birth	Employer
Secondary Insurance Company		
ID#	Group #	Effective Date
Subscriber Name		**Relationship to Patient**
Social Security Number	Date of Birth	Employer

You may be dilated at the time of your exam. If you are sensitive to dilation drops, and you believe you can not drive, please let the front desk staff know to call a driver for you, or bring a driver with you. The drops administered normally do not affect driving capabilities but could vary for everyone. It is your responsibility to know if you are capable of driving.

_____ _____
Patient's signature **Today's date**

OPHTHALMIC HISTORY

Height_____ **Weight**_____

Allergies_____

PAST EYE HISTORY:

_____

_____

_____

PAST EYE SURGERY:

_____

_____

_____

CURRENT EYE MEDICATIONS:

_____

_____

_____

_____

MEDICAL HISTORY

PAST MEDICAL HISTORY:

_____

_____

_____

PAST MEDICAL SURGERY:

_____

_____

_____

CURRENT MEDICATIONS:

_____

_____

_____

FAMILY HISTORY **Check ALL that apply**

- ☐ Diabetes Mellitus
- ☐ Cancer
- ☐ Heart Disease
- ☐ Stroke
- ☐ TB
- ☐ Kidney Disease
- ☐ Blindness
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Retinal Disease
- ☐ High Blood Pressure
- ☐ Arthritis
- ☐ Lazy Eye
- ☐ Other: Please Specify_____

_____

_____

_____

SMOKING

- ☐ Current smoker
- ☐ Former Smoker
- ☐ Never Smoked

How Much? _____

ALCOHOL USE

- ☐ Yes
- ☐ No

How Much? _____

RECREATIONAL DRUG USE

- ☐ Yes
- ☐ No

Specify _____

ASSIGNMENT OF BENEFTIS/PHI

This is a direct assignment of my rights and benefits under this policy.
I understand that services rendered to me by TOC Eye are my financial responsibility and the provider will bill my insurance for each service rendered. I understand by using my insurance in this office that it is my responsibility to do the following:

- Obtain a referral (if applicable)
- Pay any coinsurance/deductible/copayments at the time of service according to my insurance contract. I understand this is an estimate and all costs associated with patient responsibility is determined upon my claim being finalized.
- Pay any outstanding balance on my account prior to being seen.
- Pay any expenses that are not covered by my insurance.
- I understand and acknowledge that I am personally responsible to pay TOC Eye in full for services that my health insurer will not cover due to nonpayment of my health insurance premium.
- I authorize the release of the information as necessary to process my insurance claim and understand that there may be associated costs for providing information beyond what is necessary for the adjudication of a clean claim.
- I have chosen to assign the benefits knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim to TOC Eye.
- I authorize my insurance company and or Medicare to pay The Ophthalmic Center for services provided to me. I also understand that should my insurance company send payment to me; I will forward the payment to TOC Eye within 48 hours. I agree that if I fail to send the payment to the provider and they are forced to proceed with the collections processes I will be responsible for any cost incurred by the office to retrieve the monies.
- I understand that the staff at TOC Eye will make every effort to inform me of charges that will not be covered by my insurance. I understand a benefit investigation will be done on my behalf as a courtesy, this is not a guarantee of benefits. We require you as the patient to contact your insurance carrier regarding all of your deductibles, copayments, and coinsurance requirements.
- Cancelation policy/COVID surcharge: I understand I am required to give TOC Eye 24 hours' notice of cancelation of my appointment. There is a $35 No show fee in addition to a COVID surcharge of $60.00.

AUTHORIZATION FOR USE OF DISCLOSURE OF PROTECTED HEALTH INFORMATION:

I authorize my physician and/or administrative and clinical staff of The Ophthalmic Center to disclose general medical information and other protected health information to the following persons and/or entities listed below. If no one is listed below, protected health care information will not be disclosed except in those situations described in the Notice of Privacy Practices.

Name and relationship of person(s) who you wish to allow access: (e.g., your spouse, son, daughter, sibling, caretaker, friend)

Name of Person or Entity: **Relationship:**

_____

_____

_____

I have been provided a copy of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to read and understand and consent to use and disclosure of protected health information about myself for treatment, payment and health care operations.

I understand the risks associated with email and prefer to be emailed anyway. I will not hold The Ophthalmic Center responsible for lost or stolen passwords if someone gains unauthorized access to my email account.

I understand all the above regarding Assignment of Benefits, Office Polices, and PHI.

_____ Signature of the Patient or Patient Representative

Patient Signature

Date: