Patient Registration & History

Patient's Name ______________________ Date of Birth ______________________

Street Address ______________________ Spouse\Guardian ______________________

City ______________________ State ____________ Zip ______________________

Home Phone ______________________ Work Phone ______________________

Occupation ______________________ Employer ______________________

Sports\Hobbies ______________________

Purpose of todays visit (Routine, Eye Irritation, Lost Glasses, etc.) ______________________

____

—- Ocular History —-

Date of last **Eye Examination** ____________ Doctor ______________ Town ______________

Do you or have you worn glasses?_______ Type (Single Vision, Bifocal, Progressive) ______________

Do you or have you worn Contacts? ______ Type (Soft, Gas Perm, Astigmatic, Etc.) ______________

Are you interested in Contact Lenses? _______ Why? ______________________

Current Contact lens wearers:

Brand of Solutions ______________ Type of Disinfection ______________

Average wearing time______________ If extended wear - how many days ______________

—- Physical History —-

Date of Last **Physical Exam** __________ Doctor ______________ Town ______________

Are you taking any medications?_______ If so - please list (ie Vitamins, Insulins, Oral Contraceptives, etc.)

____

Do you have any Allergies? _______ If so - To what? ______________________

Women: Are you pregnant? _______ If so - How many weeks? ______________________

Do you, or any blood relatives have any of the following? ***(Please indicate S = Self F = Family)***

_____Asthma / Lung Disease	_____Double Vision	_____Cataracts
_____Heart / Vascular Disease	_____Color Blindness	_____Glaucoma
_____Intestinal / Digestive Prob.	_____Retinal Disease	_____Blindness
_____Cancer / Tumors	_____Sudden Vision Loss	_____Eye Surgery
_____High / Low Blood Pressure	_____Flashes / Floaters / Spots	_____Dry Eye / Irritation
_____Diabetes / Hypoglycemia	_____Eye Turn / Lazy Eye	_____ Eye / Head Injury
_____Thyroid Disease	_____Eye Exercise / Vision Training	_____Severe Headaches
_____Fainting / Dizziness	_____ Poor Vision Even with Glasses	_____Arthritis

Who may we thank for referring you? - Yellow pages , Newspaper, Direct Mailing, Company, Friend\Relative(Name) ______________________

PROFESSIONAL FEES ARE DUE AT THE TIME SERVICES ARE RENDERED. A $5 (FIVE DOLLAR) BILLING CHARGE WILL BE APPLIED TO ALL OUTSTANDING BALANCES, UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE. THE RETURNED CHECK FEE IS $25 (TWENTY FIVE DOLLARS). PATIENTS ARE RESPONSIBLE FOR ALL COSTS ASSOCIATED WITH COLLECTIONS OR LEGAL ACTIONS.

This information is confidential and was given by (signature) ______________________

Date ______________________

——— *OVER PLEASE FOR INSURANCE INFORMATION* ———

Insurance Policy

Due to the ever-increasing number of insurance carriers and plans,
We have been forced to institute the following insurance policy.

Your insurance coverage is a contract between you and your insurance company. It is up to **you** to **know your policy**. Even with a referral your insurance company may not pay and your services not be covered. You will be financially responsible for services rendered if your insurance company denies payment to us. If you have any questions, please call your insurance company directly.

It is your responsibility to obtain any and all referrals. Referrals cannot be backdated, as this is insurance fraud. If you do not have a referral, and one is required by your insurance, you are **expected to pay for your visit at the time of service**. We will supply you with a receipt so that you may apply for reimbursement from your insurance company.

We accept assignment from many insurance companies. The companies pay a percentage of the approved amount. It is the patient's obligation and the law that you pay any remaining deductible and balance between the approved amount and the amount paid by the insurance company. If for any reason your insurance company does not pay for your visit, it then **BECOMES YOUR RESPONSIBILITY**. It is your responsibility to know the contract between you and your insurance company. Please provide us with all the necessary information including the address and telephone number of your insurance company.

Insurance Carrier:________________________ Phone#:________________________

Insurance Address:____

Policy #:________________________ Group #________________________

Name of Card Holder:________________________ SS#:________________________

Birth Date of Card Holder: ________________________

Card Holders Employer:________________________ Phone #:________________________

Patient's Name:________________________ SS#:________________________

Patient's Birth Date:________________________ Relationship to Cardholder:________________________

We will directly bill your insurance company as a courtesy to you only when the below criteria have been met:

1. Benefits must be verified by our office **prior** to any service.
2. Patient liability must be paid at time services are rendered.
3. For those companies that we do not have a contract with, a **credit card imprint** must be left with us as a security guarantee for payment.

If your insurance company does not pay your balance within 90 days, you will be notified that payment is owed by you. If after 10 business days, you have not paid your balance or contacted us for payment arrangements, your credit card will be billed.

I have read, understand and am willing to comply with the above mentioned insurance policy.

Signature:________________________ **Date:**________________________

All insurance companies state that we must have on file your signature for release of records and authorizing payments. Please sign and date in the boxes below.

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim. I also request payment of benefits to either myself or the party who accept assignment of benefits.
Signature ________________________ Date ________________________

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical\optical benefits to J. Scot Ellis,O.D. for Optometric and Optical services.

Signature ________________________ Date ________________________