WAKE OPHTHALMOLOGY ASSOCIATES, P.A.

Patient Registration Form

(please print neatly and complete ENTIRE form)

First Name _____ **Middle Initial** _____ **Last Name** _____

Preferred Name _____ **Date of Birth** _____ **SSN#** _____

Mailing Address _____ **Apt#** _____ **City** _____ **State** _____ **Zip** _____

Home phone (_____)_____ **Work phone** (_____)_____ **Cell phone** (_____)_____

Email _____ **Preferred contact method** _____

Sex: Male / Female (Circle one) **Marital status: single / married / widowed / divorced (circle one)**

Emergency Contact _____ **Relationship** _____ **Phone#** _____

Patient's Employer_____ **Work Address**_____

Pharmacy name _____ **Pharmacy Location** _____ **Pharmacy phone#** _____

If you were referred by another physician, what is the doctor's name? _____

If not, how did you hear about our practice? _____

Is this visit related to an on-the-job injury or auto accident? _____

Who is your primary care physician? _____

Drug allergies _____

Medical Conditions _____

Parent/Guardian/Responsible Party Information (if patient is under *18* years of age)

Name _____ **SSN** _____ **Date of Birth** _____

Address _____ **Apt#** _____ **City** _____ **State** _____ **Zip**_____

Home phone (_____) _____ **Work phone** (_____) _____ **Cell phone** (_____) _____

Employer Name _____ **Employer Phone number** _____

WAKE OPHTHALMOLOGY ASSOCIATES, P.A.

Insurance Information - MEDICAL

Primary Insurance _____ **ID#** _____

Policy holder's Name _____ Policy holder's Date of birth _____

Relationship to Policy holder _____

Secondary Insurance _____ **ID#** _____

Policy holder's Name _____ Policy holder's Date of birth _____

Relationship to Policy holder _____

Insurance Information – VISION

Primary Insurance _____ **ID# or SSN#** _____

Policy holder's Name _____ Policy holder's Date of birth _____

Relationship to Policy holder _____

Workman's compensation information (if applicable)

Supervisor's name _____ Supervisor's phone number _____

Financial Assignment and Agreements

- I understand that is my responsibility to pay any deductibles, copays, coinsurance or other balances not paid by my insurance company including but not limited to glasses, contact lenses, contact lens fittings or routine examinations.
- I understand that I may be asked to make a copay at every visit.
- I request that payment of authorized insurance benefits be made on my behalf for any services furnished. I authorize any holder of medical information about me to release to the Health Care Financing Administration, its agents, or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services.
- Many insurance companies do not cover the portion of the eye exam, a refraction, that determines the need for glasses or a change in a patient's prescription. For example, Medicare does not pay for the refraction under any circumstances. I understand that this charge is my responsibility if not covered by my insurance.
- I understand that it is my responsibility to provide accurate insurance information at every visit in order for my claim to be properly filed. If I do not provide the proper insurance information, I understand that I will be responsible for payment in full.
- I understand Wake Ophthalmology files my insurance on my behalf as a courtesy to me. If there is any remaining balance after my insurance pays, I am expected to make payment in full when the statement is sent to me. If a second bill is sent to me, I understand that a $10 late fee will be applied.
- I understand there is a $25 service charge for returned checks
- All services rendered to minor/dependent children of divorced or separated parents are the financial responsibility of the parent who booked the appointment for the child. We do not get involved in who is court ordered to pay for medical bills or maintain current medical insurance for said minor/dependent child.

Acknowledgment – Notice of Privacy Practices

I hereby acknowledge that a copy of Wake Ophthalmology's Notice of Privacy Practices has been made available to me to review and that a copy is available at my request. I authorize Wake Ophthalmology to communicate with me by phone, answering machine, letter, postcard, or email regarding appointments, care, or billing.

Date:_____ Signature_____ Printed name _____

WAKE OPHTHALMOLOGY ASSOCIATES, P.A.

Authorization for Release of Information

Patient Information:

Name _____ Date of Birth _____

Address _____ Apt# _____

City, State, Zip _____

Wake Ophthalmology Assoc., PA is authorized to release protected health information pertaining to the above named patient to the entities listed below. *I have been given a copy of the Notice of Privacy Practices for the above named practice.*

Description of information to be released (please **initial** each item that you are authorizing to be released)

_____All information

_____ Financial/Billing information

_____Medical information including results from any diagnostic tests

_____Other information as described:_____

_____

Entity to Receive Information

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

Patient Rights

I understand that I have the right to revoke this authorization at any time by sending a written notification. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I have the right to inspect or copy the protected health information to be used or disclosed as described in this document. I can do this by written notification. I understand that my treatment will not be conditioned on signing this authorization. I understand that I have the right to refuse to sign this authorization.

_____

Signature of Patient or Personal Representative Date

_____

Print or Type Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority (please attach legal documentation)

For Office Use Only:

We were unable to obtain the acknowledgment for the following reason:

_____ An emergency existed and signature not possible _____ Patient refused to sign _____Unable to communicate with patient

_____Other_____ Prepared by _____

WAKE OPHTHALMOLOGY ASSOCIATES, P.A.

Patient Medical History

Please list all medications you are taking (including over the counter medications, vitamins and supplements) or indicate "NONE" if you do not take anything: _____

_____

_____

Please list any health conditions: _____

_____

Please list any drug allergies or indicate "none": _____

Are you allergic or sensitivite to Latex? _____

Have you ever had any of the following eye diseases? Please check all that apply and give dates for any surgeries.

- □ Cataract _____
- □ Corneal Disease or Transplant _____
- □ Diabetic Eye Disease _____
- □ Glaucoma _____
- □ Lazy Eye (Amblyopia) _____
- □ Macular Degeneration _____
- □ Retinal Detachment or Hole _____
- □ Injury _____

List any Eye Surgeries including Laser Treatment _____

Do you have any family history of the following: (please circle all that apply)

Cataracts Diabetes Glaucoma High Blood Pressure Macular Degeneration Retinal Detachment

Other Retinal Diseases (please list) _____

When was your last eye examination? _____

What is the reason for your visit today? _____

Do you wear glasses and, if so, what do you use them for? _____

Do you wear contact lenses and, if so, what do you wear (name, power, base curve, etc)? _____

Patient Signature _____ **Date:** _____