MEDICAL EYE CENTER
OPHTHALMOLOGY &
OPHTHALMIC SURGERY

NEW PATIENT
REGISTRATION FORM

Welcome New Patient!

Thank you for choosing Medical Eye Center for your eye examination. To make your first visit as comfortable as possible, we ask that you prepare in advance and bring several items with you to your appointment. If you have any questions, please feel welcome to call us for help.

- **Complete the following forms and bring them with you.** By completing the forms in advance at your home, you have time to look up or verify hard-to-remember dates or facts. Your list of medications is extremely vital to us, so please take time to complete it.
- **Bring all of your current eyeglasses and/or contact lenses**. Please bring all of your current eyewear, including non-prescription reading glasses. It is helpful, but not necessary, to have a copy of your written prescription. **Attention contact lens wearers:** Please be sure to tell us **before you come in** that you are a contact lens wearer so we may discuss our contact lens policies with you.
- **Bring your health insurance card(s) and bring photo I.D.** Please bring your health insurance card so that we may make a copy. If you do not have insurance coverage, payment is expected in full at the time of service, unless you have made other arrangements.
- **Bring written referral or referral number from your doctor, if your health plan requires it.** Some health insurances require a "referral" from your primary care physician. It is your responsibility to understand the terms of your insurance. **Please call your primary care office a week in advance** of your appointment with us to secure your referral. Some insurances offer an annual eye exam benefit without referral. You are welcome to take advantage of that benefit with us, but please note the following; **If you require any testing for pre-existing or newly discovered conditions,** you will have to return with a referral to complete the testing. **We recommend that you secure a referral if you are diabetic, have cataracts or glaucoma, or have been told you are a glaucoma suspect. If you are experiencing eye pain, migraines or have noticed an increase in floaters or experienced a sudden loss of vision, you should secure a referral.**
- **Although we accept most medical insurance plans, it is your responsibility to check with us before your appointment and to call your insurer to verify that we are a plan provider.** Your insurance coverage is a contract between you, your employer (if applicable), and the insurance company; we are not a party to contact. We must emphasize that as healthcare providers, our relationship is with you, not with your insurance company. Before your visit, please contact your insurance company to verify the physician and the facility that you are scheduled with participates with your plan and that the services that you intend to receive are covered. We also accept VISA and MasterCard. Some Insurance plans cover routine eye exams differently than a medical exam. If your plan has this coverage please inform the receptionist at check-in/out. Please be aware that if during the course of a routine exam a medical condition is recognized that requires testing or treatment your examination will not be able to be billed as routine and will be submitted as a medical diagnosis for insurance consideration. Some services require a Prior Authorization, Pre-Certification or Pre-Notification before rendering. Our office will take the responsibility for obtaining those from your insurance carrier.

We look forward to meeting you. Please plan to arrive 10–15 minutes early so that we may review your paperwork and introduce ourselves. We strive to run our schedule on time and will not keep you waiting long. Warmest greetings and welcome to the practice. –Office Staff

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Patient Information

Name: ☐ Mr. ☐ Ms . ☐ Mrs. ☐ Dr. _____
(First) (Middle) (Last)

SSN:_____-_____-_____ Date of Birth:_____/_____/_____ Sex: ☐ Male ☐ Female

Street Address (or PO Box) :_____

City:_____ State:_____ Zip:_____

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Life Partner

Phone: (H)_____-_____-_____ (W) _____-_____-_____ (Cell) _____-_____-_____

May we leave a message on your home, work, or cell phone regarding appointment reminders? ☐ Yes ☐ No

Email Address:_____

Emergency Contact:_____ Emergency Contact Phone: _____-_____-_____

Responsible Party Information

Party responsible for patient's bill: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Name: ☐ Mr. ☐ Ms. ☐ Mrs. ☐ Dr. _____
(First) (Middle) (Last)

SSN:_____-_____-_____ Date of Birth:_____/_____/_____ Sex: ☐ Male ☐ Female

Street Address (or PO Box) :_____

City:_____ State:_____ Zip:_____

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Life Partner

Phone: (H)_____-_____-_____ (W) _____-_____-_____ (Cell) _____-_____-_____

Your Doctors

Primary Care Physician:_____ Phone: _____-_____-_____

Referring Physician:_____ Phone: _____-_____-_____

Endocrinologist (If any):_____ Phone: _____-_____-_____

I certify that the information above is accurate and true to the best of my knowledge and is only to be used for treatment, billing, & processing of insurance benefits. I will not hold my physician or any member of Medical Eye Center responsible for any errors or omissions that I have made in the completion of this form. I further authorize the release of any necessary information, including medical information, to my insurance company in order to determine insurance benefits to which I may be entitled. This authorization may be revoked by me at any time in writing. I authorize MEC to release and or send medical information regarding my case to other consulting and/or referring physicians. I understand and agree that regardless of my insurance status, I am responsible for the balance on my account for any professional services rendered. I understand that without a proper referral or authorization from my HMO/PPO, I am financially responsible for charges incurred for services rendered by MEC on all dates of services. I also understand that I alone am responsible for obtaining my authorization or referral from my HMO/PPO primary care physician. I understand that I am responsible for charges incurred for services considered to be non-covered by my HMO/PPO.

Signature:_____ **Date**:_____/_____/_____

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Medical and Social History

Patient Name:_____ Account Number:_____ _(office use only)

Do you currently have problems in the following areas? Check all that apply...

Visual Function:

Reading books or newspapers	O Yes	O No
Recognizing people when close	O Yes	O No
Driving during the day	O Yes	O No
Driving at night	O Yes	O No
Reading traffic/street signs	O Yes	O No
Writing checks/completing forms	O Yes	O No
Cooking/hobbies/watching tv	O Yes	O No

Other:_____

Eye Conditions:

Eye Disease	O Yes	O No
Eye Injury	O Yes	O No
Eye Surgery	O Yes	O No
Eye Infection	O Yes	O No
Drooping Eye Lids	O Yes	O No
Crossed/Lazy Eyes	O Yes	O No

Other:_____

☐ Do wear glasses? If yes, how old is your present pair of glasses? _____

☐ Do wear contact lenses? If yes, how old is your present pair of lenses?_____

Type of contact lenses O rigid O soft O extended wear O other Brand:_____

Medical History

Diabetes Mellitis	O Yes	O No	Anemia	O Yes	O No
Heart Disease	O Yes	O No	Depression	O Yes	O No
High Blood Pressure	O Yes	O No	Kidney Disease	O Yes	O No
High Cholesterol	O Yes	O No	HIV/AIDS	O Yes	O No
Cancer (Type:_____)	O Yes	O No	Stroke	O Yes	O No
Arthritis	O Yes	O No	Migraines	O Yes	O No
Thyroid Disease	O Yes	O No	Osteoporosis	O Yes	O No

Other:_____

Family History

Diabetes Mellitis	O Yes	O No
Macular Degeneration	O Yes	O No
High Blood Pressure	O Yes	O No
Glaucoma	O Yes	O No
Cancer (Type:_____)	O Yes	O No
Cataracts	O Yes	O No

Other:_____

Social History

Alcohol	O Yes	O No
Exercise	O Yes	O No
Drugs	O Yes	O No
Smoking	O Yes	O No

Please note any family history for the following: Mother (M), Father (F), Sisters (S), Brothers (B), Grandparents (GP), Aunt (A), Uncle (U)

If you are a woman, is there a chance you might be pregnant and/or nursing? O Yes O No

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Patient Name:_____ Account Number:_____ (office use only)

Allergies:

Do you have any allergies to medication? O Yes O No

If yes, explain severity and reaction:_____

O Seasonal O Latex O Other:_____

List and medications you take (including oral contraceptives, asprin, over the counter medications, supplements and eye drops)

Medication	Dosage

Preferred Pharmacy:_____ Phone:_____

Systemic Problems: *(Please check all that apply)*

Fatigue	O Yes O No	Pain with Urination	O Yes O No
Weight Loss/Gain	O Yes O No	Blood in Urine	O Yes O No
Hearing Loss	O Yes O No	Rashes	O Yes O No
Sinus Problems	O Yes O No	Dry Skin	O Yes O No
Shortness of Breath	O Yes O No	Excessive Thirst	O Yes O No
Cough	O Yes O No	Bulging Eyes	O Yes O No
Chest Pain	O Yes O No	Headaches	O Yes O No
Palpitations	O Yes O No	Depression	O Yes O No
Abdominal Pain	O Yes O No	Dizziness	O Yes O No
Nausea/Vomiting	O Yes O No	Joint Swelling	O Yes O No
Heartburn	O Yes O No	Bleeding/Brusing	O Yes O No

Other:_____

Patient Signature:_____ Date:_____