# Patient Registration

Park Eye CENTER

Thank you for helping us to provide you with personal and comprehensive eye care, as well as efficient office processing. The information in this confidential questionnaire is critical to your eye evaluation and is required by insurances and governmental agencies.

Today's Date _____ Date

**BIOGRAPHICAL INFORMATION:**

First Name _____ Last Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email _____ Preferred Method Of Contact _____

Soc. Sec. # _____ Employer _____

Vision Insurance _____ Medical Insurance _____

Guarantor Name _____ Guarantor DOB _____

Primary Care Physician _____ What Town? _____

**WHO REFERRED YOU TO OUR OFFICE?**

☐ Family, Friend _____

☐ Another Doctor _____

☐ Insurance list ☐ Yellow pages ☐ Advertisement ☐ Location is convenient

**VISION HISTORY:** (If answer is yes, please describe on lines provided)

| Y | N | | |
|---|---|---|---|
| ☐ | ☐ | Do you currently wear eyeglasses? | Used for: ☐ Constant ☐ Distance ☐ Near tasks |
| ☐ | ☐ | Have you ever had eye surgery? If so, when and what type? | _____ |
| ☐ | ☐ | Have you ever been diagnosed with a medical eye disorder? If so, what type? | _____ |
| ☐ | ☐ | Has a family member (other than your spouse or children) ever been diagnosed with a medical eye disorder? | _____ |
| ☐ | ☐ | Do you currently wear contact lenses? If so, what type? | _____ |
| ☐ | ☐ | Would you ever consider laser vision surgery? | |

Please list any troublesome eye or vision symptoms you experience:

_____

_____

_____

**(OVER)**

**SOCIAL HISTORY**:

Marital Status: ☐ Married ☐ Not Married ☐ Widowed

Occupation: _____ Hobbies _____

Alcohol Intake: ☐ None ☐ Social Only ☐ Weekly ☐ Light Daily ☐ Moderate Daily ☐ Heavy

Tobacco Use: ☐ None ☐ Cigarettes -- packs per day: _____ ☐ Other _____

Substance Abuse: ☐ No History ☐ Previous History ☐ Current History

**MEDICAL HISTORY:** (if yes, please describe on lines provided)

| Y | N | | |
|---|---|---|---|
| ☐ | ☐ | Ears, nose, mouth & throat | _____ |
| ☐ | ☐ | Cardiovascular (**blood pressure**, heart, cholesterol) | _____ |
| ☐ | ☐ | Pulmonary (lungs, breathing) | _____ |
| ☐ | ☐ | Gastrointestinal (stomach, digestion, colon) | _____ |
| ☐ | ☐ | Genitourinary (reproductive, bladder) | _____ |
| ☐ | ☐ | Musculoskeletal (muscles, bones, joints) | _____ |
| ☐ | ☐ | Skin | _____ |
| ☐ | ☐ | Allergy (seasonal, hives, reactions to medicines) | _____ |
| ☐ | ☐ | Neurological (brain, nerve function) | _____ |
| ☐ | ☐ | Psychiatric (emotional) | _____ |
| ☐ | ☐ | Endocrine (**diabetes**, thyroid) | _____ |
| ☐ | ☐ | Hematological (blood) | _____ |
| ☐ | ☐ | Immunologic (resistance, HIV) | _____ |
| ☐ | ☐ | Oncology (cancer) | _____ |

**MEDICATIONS CURRENTLY TAKEN**: (if you have a prepared list, please present to staff for copying)

_____

**PAYMENT TERMS:**

We are happy to assist you in the filing of your insurance claim. If your insurance will not pay the contractual amounts, or if your insurance pays you directly, we ask that you pay the balance. Office policy calls for payment at the time of service. If eyewear or contact lenses are to be ordered, a 50% deposit is customary and the balance is due upon delivery. We accept cash, checks, Visa, MasterCard and American Express. If it is necessary we will refer your account to a collection agency. You agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 50% of the debt, and all costs, and expenses, including reasonable attorneys' fees we incur in such collection efforts.

I hereby authorize payment directly to Dr. Chani C. Miller, O.D., for any services rendered to me by Dr. Chani C. Miller, O.D., or any of her authorized agents.

I authorize Dr. Dr. Chani C. Miller, O.D., or any of her authorized agents to assist me in obtaining payment from my health insurance companies.

I authorize a copy of this "Signature on File" form to be used in place of the original and that this copy may be used on all of my insurance submissions.

**RELEASE OF INFORMATION:**

I hereby authorize Park Eye Center to disclose to my insurance company(s) copies of my medical records to obtain payment for services or as part of a payment review of medical services. Additionally, I authorize Park Eye Center to release copies of my medical records to other health care providers serving as consultants to my physician, including referrals for treatment.

**I acknowledge that the notice of privacy practice has been made available to me.**

I have read and agree to the terms set forth above:

SIGNATURE _____ DATE _____