

# EYECARE REGISTRATION AND HISTORY

## 1

### PATIENT INFORMATION

Date \_\_\_\_\_

SS/HIC/Patient ID # \_\_\_\_\_

Patient Name \_\_\_\_\_  
Last Name

\_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

E-mail \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Married  Widowed  Single  Minor

Separated  Divorced  Partnered for \_\_\_\_\_ years

Occupation \_\_\_\_\_

Patient Employer/School \_\_\_\_\_

Employer/School Address \_\_\_\_\_

Employer/School Phone (\_\_\_\_) \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## 2

### INSURANCE

Who is responsible for this account? \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

Is patient covered by additional insurance?  Yes  No

Subscriber's Name \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Group # \_\_\_\_\_

**ASSIGNMENT AND RELEASE**  
 I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ and assign directly to \_\_\_\_\_  
Name of Insurance Company(ies)

Dr. \_\_\_\_\_ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

\_\_\_\_\_  
 Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
 Please print name of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Relationship to Patient

## 3

### PHONE NUMBERS

Home (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_ Spouse's Work Phone (\_\_\_\_) \_\_\_\_\_ Ext \_\_\_\_\_

Best time and place to reach you \_\_\_\_\_

**IN CASE OF EMERGENCY, CONTACT** (Specify someone who does not live in your household.)

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Ext \_\_\_\_\_

## 4

### EYE HEALTH HISTORY

Physician's Name \_\_\_\_\_

Date of last visit \_\_\_\_\_

Date of last eye exam \_\_\_\_\_

Name of doctor \_\_\_\_\_

Do you wear glasses?  Yes  No

All the time  Occasionally

Reading  Driving  TV

Do you wear contacts?  Yes  No

Type \_\_\_\_\_ Hours/Day \_\_\_\_\_

Describe any problems you have with your contacts \_\_\_\_\_

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Bloodshot Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Floaters or Spots	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blurred Vision – Distance	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blurred Vision – Near	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No
Burning Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Itching Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Light Sensitive	<input type="checkbox"/> Yes <input type="checkbox"/> No
Color Vision, Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No	Loss of Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No
Crossed Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraine Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No
Discharge from Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Night Vision, Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dizzy Spells	<input type="checkbox"/> Yes <input type="checkbox"/> No	Red Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Double Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seeing Halos	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dry Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seeing Flashes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eye Infection	<input type="checkbox"/> Yes <input type="checkbox"/> No	Temporary Loss of Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eye Injury	<input type="checkbox"/> Yes <input type="checkbox"/> No	Twitching Eyelid	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eye Strain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vision Poor	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fainting Spells, Blackouts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Watering Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No

# 5

## HEALTH HISTORY

Physician's Name \_\_\_\_\_ Date of last visit \_\_\_\_\_

Place a mark on "Yes" or "No" to indicate if you have had any of the following. Also place a mark to indicate if a blood relative has had any of the following problems.

	Yourself		Family Members			Yourself		Family Members	
AIDS/HIV	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis (Type _____)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Artificial Heart Valve	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Lazy Eye	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Lupus	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bleeding	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Migraine Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blindness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Poor Color Vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Retinal Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Shingles	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Drug Sensitivity	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Skin Conditions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thyroid Conditions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Eye Surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Turned Eye	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hay Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are you pregnant? _____	Number of children _____			
Heart Condition	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tobacco use _____	Alcohol use _____			

### MEDICATIONS

List any medications you are currently taking, including eye drops:

\_\_\_\_\_

\_\_\_\_\_

Pharmacy Name \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_

### ALLERGIES

List your allergies to medications or other substances:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# 6

## MEDICARE/MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to

\_\_\_\_\_ for any services furnished to me by that provider.  
Name of Doctor or Clinic

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

\_\_\_\_\_  
Signature of Beneficiary, Guardian or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please print name of Beneficiary, Guardian or Personal Representative

\_\_\_\_\_  
Relationship to Beneficiary



**Pharmacy Information**

**Cancellation / Missed Appointment Policy**

Today's Date: \_\_\_\_\_

Patient Name: *please print clearly*

Last: \_\_\_\_\_

First: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Gender: Male \_\_\_\_\_ Female \_\_\_\_\_

Pharmacy information:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number: \_\_\_\_\_

**Cancellation / Missed appointment Fee -- \$25**

We understand that plans and emergencies arise. Please notify us as soon as possible if you need to cancel or reschedule your appointment. Eye Institute of New York has a 24 hour cancellation policy. This means that missed appointments, same day cancellations or rescheduled appointments are subject to a **\$25.00 Cancellation Fee** for office visits. These fees are applied whether or not you receive a reminder call or email from our office. They also apply to appointments made just one day in advance. All cancelled/rescheduled appointments must be made during business hours with a staff member. Do not leave a voicemail or send email. Please help us service you better by keeping scheduled appointments. Thank you.

Patient Signature: \_\_\_\_\_



**REFRACTION EXCLUSION**

Refraction is the testing done to *determine the glasses prescription*. It is done with lenses to measure and correct problems with both distance and/or near vision. This testing is required in order to prescribe glasses.

**Insurance Carriers do not consider refraction a medical procedure.**

Medicare and most commercial carriers will pay for covered benefits only. When a patient receives a service that is not a covered benefit, the patient is responsible to pay for it.

**SERVICE:      REFRACTION (92015)                      FEE: \$75**

*Please check one box if you want to have this part of the examination. If you answer, YES, the payment is due on the date of service.*

**Must check one before seeing the doctor or technician**

YES                                       NO

Signing below means that you have received and understand this notice. You can also receive a copy.

**Please Note: If there is no change in your glasses prescription but you are opting to get new frames and/or lenses, the refraction test must be performed as a glasses prescription is only valid for 1 year.**

**Payment must be made on day service is rendered**

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



**Early Detection Testing Now Available**

**Glaucoma and Macular Degeneration are *leading causes of blindness*.** Early detection of these diseases is essential to preserve vision. We, at The Eye Institute of New York, are proud to remain at the forefront of eye care technology. This new technology allows us to investigate parts of the eye to enable earlier detection and treatment of potentially vision threatening diseases. These tests are fast, painless and do not require drops.

The doctors ***strongly recommend*** screening with this new technology if any ONE of the following applies to you.

**Please check all that apply:**

- A doctor has treated you or said you have elevated eye pressure
- A doctor has treated you or said you have suspicious optic nerves
- A doctor has treated you or said you have glaucoma
- Family member with elevated eye pressure or glaucoma
- African American, Asian, or Hispanic
- Long-term use of steroid medication
- Experience haloes around lights
- High nearsightedness or farsightedness
- History of trauma to the eye
- History of a retinal tear or retinal detachment
- Family member with macular degeneration

Any of the following medical conditions:

- High blood pressure
- Heart disease
- Thyroid condition
- Sleep apnea
- Diabetes

**Unfortunately, insurance plans do not pay for these screenings.** Please check YES if you want to have this important screening as part of your examination. If you answer, YES, the payment is due on the date of service.

SERVICE:      Early Detection Screening      FEE: \$40.00

[   ] YES                      [   ] NO

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



**PATIENT CONSENT FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION**

I hereby give my consent for EYE INSTITUTE OF NEW YORK to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operation (TPO). (EYE INSTITUTE OF NEW YORK’S Notice of Privacy Practices provides a more complete description of such uses and disclosures).

I have the right to review the Notice of Privacy Practices prior to signing this consent. EYE INSTITUTE OF NEW YORK reserves the right to revise its Notice Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to EYE INSTITUTE OF NEW YORK’S Privacy Officer at 132 East 76<sup>th</sup> Street, Suite 2D, New York, NY 10021.

With this consent, EYE INSTITUTE OF NEW YORK may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice to my clinical care, including laboratory results among others.

With this consent, EYE INSTITUTE OF NEW YORK may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment cards and patient statements as long as they are marked Personal and Confidential.

With this consent, EYE INSTITUTE OF NEW YORK may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request the EYE INSTITUTE OF NEW YORK restrict how it uses or disclose my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to EYE INSTITUTE OF NEW YORK’S use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, EYE INSTITUTE OF NEW YORK may decline to provide treatment to me.

\_\_\_\_\_  
Print name of Patient or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient or Legal Guardian