

Patient Registration Form
Welcome to Our Office!

Date _____

Name: Last _____ First _____ M _____ Name You Go By _____

Sex: Male _____ Female _____ Date of Birth _____ Social Security # _____

Mailing Address _____ Street Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Ext. _____ Cell Phone _____

Email Address _____

If you do not wish to be contacted at any of these numbers or address, please specify. _____

Place of Employment _____ Job Title _____

Marital Status: Married _____ Single _____ Divorced _____ Widow _____

Spouse's Name _____ Spouse's Emp. _____

Spouse's SS# _____ Spouse's Date of Birth _____

In case of emergency, please notify _____

Relationship _____ Phone # _____

If the patient is a minor, please list parent or guardian information below:

Parent/Guardian Name _____

Employment _____ Phone _____

Referred by _____

Please list family members who are patients at this office: _____

PAYMENT DUE WHEN SERVICES ARE RENDERED

WE ACCEPT CASH, CHECK, MASTERCARD, VISA OR DISCOVER

INSURANCE INFORMATION

Medicare # _____ Medicaid # _____

Supplement to Medicare Company _____ # _____

(MEDICARE SUPPLEMENTS WILL BE FILED BUT IF NOT PAID WITHIN 60 DAYS PATIENT MAY BE BILLED)

Group Insurance (Most insurances do not pay for routine eye exams or glasses.)

Company _____

Policy Holder _____ Policy Holder's Date of Birth _____

Was this an accident? Yes No Date of Accident _____ Work Related? Yes No

FOR OFFICE USE

Reviewed: _____ Reviewed: _____

Reviewed: _____ Reviewed: _____

Reviewed: _____ Reviewed: _____

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Date: _____

Current Eye Medications (including OTC): _____

Current General Medications: _____

Allergies to Medicines: _____

Other Allergies: _____

Describe all serious illnesses, injuries and surgeries: _____

Primary Care Physician: _____ Phone#: _____

FAMILY HISTORY

Please note any family member with the following diseases/conditions
M-mother, F-father, S-sibling, GP-grandparent

	YES	NO		YES	NO
Arthritis	___ <input type="checkbox"/>	___ <input type="checkbox"/>	Diabetes	___ <input type="checkbox"/>	___ <input type="checkbox"/>
Blindness	___ <input type="checkbox"/>	___ <input type="checkbox"/>	Glaucoma	___ <input type="checkbox"/>	___ <input type="checkbox"/>
Cancer	___ <input type="checkbox"/>	___ <input type="checkbox"/>	Heart Disease	___ <input type="checkbox"/>	___ <input type="checkbox"/>
Cataracts	___ <input type="checkbox"/>	___ <input type="checkbox"/>	Hypertension	___ <input type="checkbox"/>	___ <input type="checkbox"/>
Crossed Eyes	___ <input type="checkbox"/>	___ <input type="checkbox"/>	Retinal Dz.	___ <input type="checkbox"/>	___ <input type="checkbox"/>

SOCIAL HISTORY

Health Habits
Check which substances you use and the consumption.

	YES	NO
Alcohol Quantity: _____	___ <input type="checkbox"/>	___ <input type="checkbox"/>
Drugs Quantity: _____	___ <input type="checkbox"/>	___ <input type="checkbox"/>
Tobacco Quantity: _____	___ <input type="checkbox"/>	___ <input type="checkbox"/>

Social History
Please indicate hobbies and interest:

	YES	NO
Computers	___ <input type="checkbox"/>	___ <input type="checkbox"/>
Fishing	___ <input type="checkbox"/>	___ <input type="checkbox"/>
Golfing	___ <input type="checkbox"/>	___ <input type="checkbox"/>
Hunting	___ <input type="checkbox"/>	___ <input type="checkbox"/>
Music	___ <input type="checkbox"/>	___ <input type="checkbox"/>
Reading	___ <input type="checkbox"/>	___ <input type="checkbox"/>

REVIEW OF SYSTEMS

PLEASE MARK EACH QUESTION YES OR NO AS PERTAINS TO PATIENT

	YES	NO		YES	NO
EYES			GENITOURINARY		
Cataracts	___ <input type="checkbox"/>	___ <input type="checkbox"/>	Chlamydia	___ <input type="checkbox"/>	___ <input type="checkbox"/>
Contacts	___ <input type="checkbox"/>	___ <input type="checkbox"/>	Gonorrhea	___ <input type="checkbox"/>	___ <input type="checkbox"/>
Crossed Eyes (Amblyopia)	___ <input type="checkbox"/>	___ <input type="checkbox"/>	Kidney Disease	___ <input type="checkbox"/>	___ <input type="checkbox"/>
Double Vision	___ <input type="checkbox"/>	___ <input type="checkbox"/>	Syphilis	___ <input type="checkbox"/>	___ <input type="checkbox"/>
Flashes/Floaters in vision	___ <input type="checkbox"/>	___ <input type="checkbox"/>	INTEGUMENTARY (Skin)		
Glasses	___ <input type="checkbox"/>	___ <input type="checkbox"/>	Eczema	___ <input type="checkbox"/>	___ <input type="checkbox"/>
Glaucoma	___ <input type="checkbox"/>	___ <input type="checkbox"/>	Psoriasis	___ <input type="checkbox"/>	___ <input type="checkbox"/>
Loss of Vision	___ <input type="checkbox"/>	___ <input type="checkbox"/>	Rash	___ <input type="checkbox"/>	___ <input type="checkbox"/>
Retinal Disease	___ <input type="checkbox"/>	___ <input type="checkbox"/>	LYMPHATIC/HEMATOLOGIC		
BONE/JOINT/MUSCLE			AIDS	___ <input type="checkbox"/>	___ <input type="checkbox"/>
Arthritis	___ <input type="checkbox"/>	___ <input type="checkbox"/>	Anemia	___ <input type="checkbox"/>	___ <input type="checkbox"/>
Joint/Muscle Pain	___ <input type="checkbox"/>	___ <input type="checkbox"/>	Bleeding Disorders	___ <input type="checkbox"/>	___ <input type="checkbox"/>
Polio	___ <input type="checkbox"/>	___ <input type="checkbox"/>	Hepatitis	___ <input type="checkbox"/>	___ <input type="checkbox"/>
CANCER			Herpes	___ <input type="checkbox"/>	___ <input type="checkbox"/>
Breast	___ <input type="checkbox"/>	___ <input type="checkbox"/>	HIV Positive	___ <input type="checkbox"/>	___ <input type="checkbox"/>
Lung	___ <input type="checkbox"/>	___ <input type="checkbox"/>	Liver Disease	___ <input type="checkbox"/>	___ <input type="checkbox"/>
Prostate	___ <input type="checkbox"/>	___ <input type="checkbox"/>	NEUROLOGIC		
Skin	___ <input type="checkbox"/>	___ <input type="checkbox"/>	Alzheimers	___ <input type="checkbox"/>	___ <input type="checkbox"/>
Other	___ <input type="checkbox"/>	___ <input type="checkbox"/>	Epilepsy	___ <input type="checkbox"/>	___ <input type="checkbox"/>
CONSTITUTIONAL			Headaches	___ <input type="checkbox"/>	___ <input type="checkbox"/>
Fever	___ <input type="checkbox"/>	___ <input type="checkbox"/>	Migraines	___ <input type="checkbox"/>	___ <input type="checkbox"/>
Weight Gain/Loss (sudden)	___ <input type="checkbox"/>	___ <input type="checkbox"/>	Multiple Sclerosis	___ <input type="checkbox"/>	___ <input type="checkbox"/>
ENDOCRINE			Seizures	___ <input type="checkbox"/>	___ <input type="checkbox"/>
Diabetes	___ <input type="checkbox"/>	___ <input type="checkbox"/>	PSYCHIATRIC		
Thyroid Abnormalities	___ <input type="checkbox"/>	___ <input type="checkbox"/>	Depression	___ <input type="checkbox"/>	___ <input type="checkbox"/>
EAR, NOSE AND THROAT			High Anxiety	___ <input type="checkbox"/>	___ <input type="checkbox"/>
Hard of Hearing	___ <input type="checkbox"/>	___ <input type="checkbox"/>	REPRODUCTIVE		
Chronic Cough	___ <input type="checkbox"/>	___ <input type="checkbox"/>	Pregnant	___ <input type="checkbox"/>	___ <input type="checkbox"/>
Dry Mouth/Throat	___ <input type="checkbox"/>	___ <input type="checkbox"/>	RESPIRATORY		
Hay Fever	___ <input type="checkbox"/>	___ <input type="checkbox"/>	Asthma	___ <input type="checkbox"/>	___ <input type="checkbox"/>
Sinus Congestion	___ <input type="checkbox"/>	___ <input type="checkbox"/>	Chronic Bronchitis	___ <input type="checkbox"/>	___ <input type="checkbox"/>
GASTROINTESTINAL (Stomach)			Emphysema	___ <input type="checkbox"/>	___ <input type="checkbox"/>
Constipation	___ <input type="checkbox"/>	___ <input type="checkbox"/>	Pneumonia	___ <input type="checkbox"/>	___ <input type="checkbox"/>
Diarrhea	___ <input type="checkbox"/>	___ <input type="checkbox"/>	Tuberculosis	___ <input type="checkbox"/>	___ <input type="checkbox"/>
Ulcers	___ <input type="checkbox"/>	___ <input type="checkbox"/>	VASCULAR		
FOR OFFICE USE			Heart Disease	___ <input type="checkbox"/>	___ <input type="checkbox"/>
Reviewed: _____	Reviewed: _____	Reviewed: _____	High Blood Pressure	___ <input type="checkbox"/>	___ <input type="checkbox"/>
Reviewed: _____	Reviewed: _____	Reviewed: _____	High Cholesterol	___ <input type="checkbox"/>	___ <input type="checkbox"/>
			Stroke	___ <input type="checkbox"/>	___ <input type="checkbox"/>

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have been presented with a copy of Wesson and Mothershed Eye Center's notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the notice, and I request the following restriction(s) concerning the use of my personal medical information:

According to federal law, this office is not allowed to release any information on you without your consent. Please list anyone we may speak to on your behalf.

NAME

Relationship to Patient

I understand that I have the right to revoke this authorization at any time by submitting a signed request to the practice.

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Signed: _____ Date: _____

If not signed by patient, please indicate relationship to patient (e.g., spouse)

Relationship: _____ Witnessed by: _____

INTERNAL USE ONLY

If patient or patient's representative refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to patient and sign below.

Presented on (date and time): _____

By (name and title): _____

SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT

Beneficiary Name (print)

Insurance Number

1. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to Wesson Ophthalmology Asso., PLLC or Mothershed Optometry Asso., PLLC, for services furnished me by Wesson Ophthalmology Asso., PLLC or Mothershed Optometry Asso., PLLC. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Wesson Ophthalmology Asso., PLLC or Mothershed Optometry Asso., PLLC accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier. **I understand that Refraction is a non-covered charge with Medicare and that I will be responsible for the cost of \$20.00.**

2. **MEDIGAP:** I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Wesson Ophthalmology Asso., PLLC or Mothershed Optometry Asso., PLLC, if possible or otherwise to me.

3. **RELEASE OF INFORMATION:** Wesson Ophthalmology Asso., PLLC or Mothershed Optometry Asso., PLLC may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to Wesson Ophthalmology Asso., PLLC or Mothershed Optometry Asso., PLLC for reimbursement for services rendered, and (2) any health care provider for continued patient care. Wesson Ophthalmology Asso., PLLC or Mothershed Optometry Asso., PLLC may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in place of the original.

4. **NON-COVERED SERVICES:** I understand that Wesson Ophthalmology Asso., PLLC or Mothershed Optometry Asso., PLLC contracts with health care service plans relate only to items and services which are "covered" by the health care services plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient; and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Wesson Ophthalmology Asso., PLLC or Mothershed Optometry Asso., PLLC to obtain necessary health care service plan authorizations.

5. **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by Wesson Ophthalmology Asso., PLLC or Mothershed Optometry Asso., PLLC, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Wesson Ophthalmology Asso., PLLC or Mothershed Optometry Asso., PLLC for payment. **If an account is sent to a collection agency for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action.** I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to Wesson Ophthalmology Asso., PLLC or Mothershed Optometry Asso., PLLC. If copayments and /or deductibles are designated by my insurance company or health plan, I agree to pay them to Wesson Ophthalmology Asso., PLLC or Mothershed Optometry Asso., PLLC. **However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.**

Beneficiary Signature or Authorized Party

Date