

**NEW PATIENT REGISTRATION**

**Primary Insurance :** Click here to enter text. **ID#** Click here to enter text.

Policy Holder’s Name:Click here to enter text. DOB: Click here to enter text.

**Secondary Insurance:** Click here to enter text. **ID#** Click here to enter text.

Policy Holder’s NameClick here to enter text. DOB: Click here to enter text.

**Patient Information**

**Name:** Click here to enter text.**Birthdate:** Click here to enter a date. **SSN:** Click here to enter text.

**Sex: M / F\ Preferred Language:** Choose an item. **Race:** Choose an item.

**Address:**Click here to enter text. **City/State/Zip:** Click here to enter text.

**Home #:** Click here to enter text.**Cell#:**Click here to enter text. **Email:**Click here to enter text.

**Pharmacy Name/City:**Click here to enter text. **Phone #:** Click here to enter text.

**Emergency Contact** Click here to enter text. **Phone #:** Click here to enter text.

**Primary Care Physician:** Click here to enter text. **Phone #:** Click here to enter text.

**Is the patient in hospice or a skilled nursing facility?** Choose an item.

**CONSENT TO TREATMENT:** I voluntarily consent to receive medical and health care services provided by EyeCare Associates of Texas, P.A. physicians, employees and such associates, assistants, and other health care providers as my physicians deem necessary. I understand that such services may include diagnostic procedures, examinations and treatment. I acknowledge that no warranty or guarantee has been made to me as to result or cure. I understand that this consent to treatment will be valid and remain in effect as long as I attend EyeCare Associates of Texas, P.A.clinics, unless revoked by me in writing.

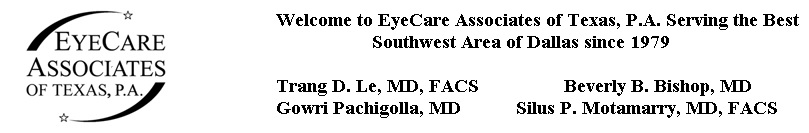
**FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS:** In consideration for receiving medical or health care services, I hereby assign my right, title and interest in all insurance, Medicare/Medicaid, or other third party payer benefits for medical or health care services payable to me, payable to the providers of EyeCare Associates of Texas, P.A.. I also authorize direct payments to be made by Medicare/Medicaid and/or my insurance company or other third party payer, up to the total amount of my medical and health care charges, to the providers of EyeCare Associates of Texas, P.A. I certify that the information I have provided in connection with any application for payment by third party payers, including Medicare/Medicaid, is correct. I agree to pay all charges for medical and health care services not covered by or which exceed the estimated amount to be paid or actually paid by Medicare/Medicaid, my insurance company, or other third party payor and agree to make payment as requested by EyeCare Associates of Texas, P.A..

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**Patient/Other Legally Authorized Signee**

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**Printed Name and Relationship to Patient** **Date**



**RELEASE OF MEDICAL INFORMATION AUTHORIZATION**

Please list any persons who you give permission to EyeCare Associates of Texas to disclose protected health information, appointment scheduling, or financial account information (i.e. spouse, child, friend, parent)

Name: Click here to enter text.Relationship:Click here to enter text.

Name: Click here to enter text.Relationship:Click here to enter text.

May we leave you a message at your residence? **YES NO**

In order to facilitate and coordinate care with your physicians, Total Eye Care will electronically access your medication history.

I have been given the opportunity to read and review EyeCare Associates Notices of Privacy Practices.

**Signature Date**

**POLICY REGARDING REFRACTION AND ROUTINE EYE EXAMS**

**Refraction** is the process of measuring the eye’s need for glasses or other corrective lenses (also called the eye’s refractive error). **Medicare and most health insurance plans do not cover this service and therefore, the patient is responsible for this charge, in addition to any co-pays or deductibles.** The refraction can be performed during a complete exam but this portion of the exam is charged separately. If performed, our fee for the refraction is $50. In the absence of a medical condition other than refractive error, Medicare and most health insurance plans consider an eye exam to be routine, and also not a covered service. Charges for routine eye exams are also the responsibility of the patient. **If you want an updated glasses or contact lens prescription we must have a refraction performed today.**

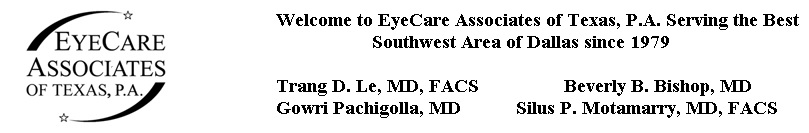
**Yes, I wish to have a refraction performed today and understand I will owe $50**

**No, I do not want to have the refraction performed today.**

**Signature Date**

**Do you need a contact lens prescription today?** Choose an item.

**If yes please be prepared to pay an additional $25 fee as this is not included in an eye exam.**



**MEDICAL HISTORY**

**Date :**Click here to enter a date. **Patient Name:**Click here to enter text.

**Primary Pharmacy Name/City:**Click here to enter text.

**Mail Order Pharmacy Name:** Click here to enter text.

**Primary reason for your visit today :**

**Cataract Evaluation**  **Diabetic Eye Exam Glaucoma Evaluation**

**Eyelid Surgery Evaluation** **Routine Eye Exam (Vision Plan Use Only)**

**Current Eye Problem Other :** Click here to enter text.

**Eye Conditions :**

Macular DegenerationYes  No Glaucoma Yes  No

Cataracts Yes  No Retinal Detachment Yes  No

Strabismus Yes  No Corneal DiseaseYes  No

Loss of Side Vision Yes  No Double Vision Yes  No

Red Eye/Discharge Yes  No Pain Yes  No

Glare/Light Sensitivity Yes  No Dry Eye/Tearing Yes  No

**Prior Eye Surgery Type/Date/Doctor** Click here to enter text.

**Eye Drops or Ointments Currently In Use:** Yes  No

List Names and Dose**:**

**Medication Name Which Eye Times Per Day Used**

Click here to enter text. Choose an item. Click here to enter text.

Click here to enter text. Choose an item. Click here to enter text.

Click here to enter text. Choose an item. Click here to enter text.

**Current Medications** List Names and Dose**:**

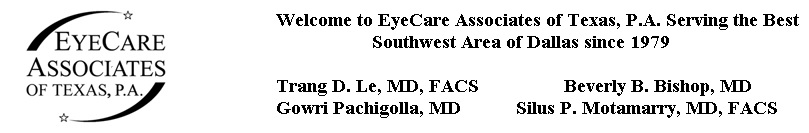
**Medication Name/Dose Times Per Day Used**

Click here to enter text. Click here to enter text.

Click here to enter text. Click here to enter text.

Click here to enter text. Click here to enter text.

Click here to enter text. Click here to enter text.



**Family History :**

Macular Degeneration Yes  No Glaucoma Yes  No

Cataracts Yes  No Retinal Detachment Yes  No

Strabismus Yes  No Corneal Disease Yes  No

Heart Disease Yes  No Diabetes Yes  No

Stroke Yes  No

**Current and Past Medical History:**

**Have you been diagnosed with any of the following? :**

Heart Disease Yes  No Asthma Yes  No

Diabetes Yes  No Emphysema Yes  No

Hypertension Yes  No

High Cholesterol Yes  No

Thyroid Disease Yes  No HIV Yes  No

Rheumatoid ArthritisYes  No Lupus Yes  No

**Do you have a Defibrillator Yes  No**

**Medication Allergies (including eye drops):**

List Names and Reaction

Click here to enter text.

**Social History :**

SmokeYes  No ❒ Former Drink Alcohol Yes  No

Caffeine Yes  No Recreational Drugs Yes  No

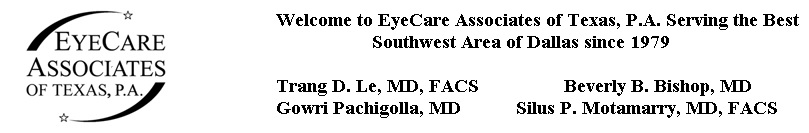
**Surgical History :**

List any major surgical procedures and date

Click here to enter text.

**List Any Other Physicians Seen Regularly Other Than Your Primary Care**

Click here to enter text.



**Payment and Treatment Policies**

Our office files your insurance as a courtesy. Your copay and/or deductible are due at the time of your visit.

**Insurance –** Insurance card and driver’s license must be presented prior to each office visit in order to utilize benefits. Please notify our office if there is a change in your insurance plan or coverage. We file claims as a courtesy to our patients and are only responsible for filing claims to contracted insurance carriers. Any dispute for unpaid charges from the insurance company will be billed directly to the patient and due upon receipt of a statement from our office.

**If you plan to utilize your routine benefits (VSP/EyeMed/AAFES) please notify us at the time of check in so that your claims may be processed correctly. If you fail to notify us we cannot re-file the claim at a later date.**

**If your insurance company requires you to have a referral for your visit you must contact your primary care doctor at least 7 days in advance of your appointment and call our office 1 day prior to your appointment to be sure we have received the necessary documentation.**

**Paperwork -** You are required to update paperwork annually. If you have not been seen by one of our physicians within the last 6 months, or come in with a new problem, you will be asked to update your information. This allows us to keep your medical record up to date so that we may provide quality care.

**Payment –** Full payment is due at the time services are rendered unless other payment arrangements have been made with our billing department prior to your visit.

**Medication Refills –** Prescription refill requests are required to be called into your pharmacy at least 5 days prior to running out of your medication to allow adequate time for approval. Refills will only be handled during normal business hours Monday through Friday. Please contact your pharmacy for refill requests.

**Appointment Reminders –** You will receive a reminder call/text from our office 2 days prior to your scheduled appointment and an email confirmation one week prior if your email is on file. Please confirm your appointment with this system if you are able to do so.

**After Hours –** Our phone message will provide you with instructions to reach the physician on call. This service is to be utilized in emergency situations only. Refill requests or routine requests for appointments will not be returned until the next business day by a staff member.

**NSF Checks –** A $25 fee will be added to your account for all returned checks.

**Minor Patients -** For all services rendered to patients age 17 or younger we will look to the adult accompanying the patient for payment. All minors must have written consent from the parent/guardian in order for us to provide treatment.

**Thank you for your business and we look forward to providing you quality eye care.**