PATIENT REGISTRATION INFORMATION

PERSONAL INFORMATION: Date: _____

Name _____ _____ __ Male __ Female
First Mid.Init. Last MD,Jr,etc Birthdate

Add. _____ _____ __ Married __ Single
Street / PO Box Social Security #

_____ ____ _____
City State Zip

Home Phone # ___ _____ Other Phone # ___ _____ __Cell __Work __Message __Other

Email _____ Allow additional e-mails __ Yes __ No
e-mail address for appt reminders and recalls

SPOUSE or PARENT INFORMATION:

Name _____ _____
Birthdate

Add. _____ _____
Street / PO Box Social Security #

_____ ____ _____
City State Zip

Phone # ___ _____ __ Home __Cell __Work

ADDITIONAL PARENT INFORMATION:

Name _____ _____
Birthdate

Add. _____ _____
Street / PO Box Social Security #

_____ ____ _____
City State Zip

Phone # ___ _____ __ Home __Cell __Work

PRIMARY INSURANCE HOLDER:

Policy Holder _____ _____
Birthdate

Employer _____

Add. _____
Street / PO Box

_____ ____ _____
City State Zip

Phone # ___ _____

Vision Insurance _____

Medical Insurance _____

SECONDARY INSURANCE HOLDER:

Policy Holder _____ _____
Birthdate

Employer _____

Add. _____
Street / PO Box

_____ ____ _____
City State Zip

Phone # ___ _____

Vision Insurance _____

Medical Insurance _____

MEDICAL INFORMATION:

Doctor _____

Add. _____
Street / PO Box

_____ ____ _____
City State Zip

Phone # ___ _____ Last Exam Date: _____

MEDICAL HISTORY:

Do you use?

Tobacco..... __ Yes __ No
Advised to quit __Y __N

Alcohol..... __ Yes __ No

Other Drugs __ Yes __ No

Do you have?

General Allergies __Y __N
_____

Medicine Allergies __Y __N

_____

MEDICATIONS:

Drug Name	Used For	Dosage	Drug Name	Used For	Dosage
1. _____	_____	_____	7. _____	_____	_____
2. _____	_____	_____	8. _____	_____	_____
3. _____	_____	_____	9. _____	_____	_____
4. _____	_____	_____	10. _____	_____	_____
5. _____	_____	_____	11. _____	_____	_____
6. _____	_____	_____	12. _____	_____	_____

**** OVER ****

CURRENT OCULAR STATUS:

Rate your vision with your current correction?

At distance .... __ Good __ Fair __ Poor

At arm's length __ Good __ Fair __ Poor

At near ..... __ Good __ Fair __ Poor

Have you been diagnosed with?

Cataracts __ Yes __ No

Glaucoma __ Yes __ No

Macular Degeneration __ Yes __ No

Are you experiencing any of the following?

Eye Strain __ Yes __ No

Double Vision __ Yes __ No

Eye Pain __ Yes __ No

Eye Redness __ Yes __ No

Eye Discharge __ Yes __ No

Flashes of Light __ Yes __ No

Floaters __ Yes __ No

Do you have special vision needs for?

Computer work __ Yes __ No

Safety glasses __ Yes __ No

Sunglasses __ Yes __ No

List any eye drops that you are using that weren't listed on side 1 of this form

	Drug Name	Used For	Dosage		Drug Name	Used For	Dosage
1.	_____	_____	_____	4.	_____	_____	_____
2.	_____	_____	_____	5.	_____	_____	_____
3.	_____	_____	_____	6.	_____	_____	_____

MEDICAL ASSIGNMENT & RELEASE AGREEMENT

I request that payment of authorized insurance benefits be made on behalf of **West Branch Eyecare** for services furnished to me by the physician. I authorize any holder of medical information about me to release the Health Care Financing Administration and its agents any information needed to determine these benefits or the payment for related services. I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If "other insurance" is indicated in the item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, non covered services, and non assigned claims. Coinsurace and the deductible are based on the charge of the assigned Medicare carrier. **I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE CHARGES NOT COVERED BY MY INSURANCE. THERE WILL BE A $3.00 PROCESSING FEE EACH BILLING AFTER THE FIRST MONTH AND A $20.00 FEE IF SENT TO A COLLECTION AGENCY.**

West Branch Eyecare is given permission to send/receive reports to/from other doctors, specialists or family members, to call in prescriptions to your pharmacy for you, and to bill your insurance. Please specify any persons you **DON'T** want information released to _____

By signing I also acknowledge that I have been offered a copy of WEST BRANCH EYECARE'S Notice of privacy practices

(signature) _____ **Dated** ____/____/____