If you are new, who referred you to us:_____ **PATIENT REGISTRATION FORM FOR ADULTS**

PATIENT'S LAST NAME	FIRST NAME	MIDDLE	GENDER	BIRTHDATE	SOCIAL SECURITY #

The Center of Medicare and Medicaid Services requires that we collect the patient's race, ethnicity and primary language.

RACE (choose one):
□ American Indian/Aleut
□ Asian
□ Black
□ Native Hawaiian/Pacific Islander
□ Other
□ Unknown
□ White
□ Spanish/Latin

ETHNICITY (choose one):
□ African
□ African American
□ Albanian
□ American
□ Asia
□ Asian Indian
□ Caucasian
□ Central American
□ Cuban
□ Ethiopian
□ European
□ Haitian
□ Hispanic, Latin
□ Iranian
□ Iraqi
□ Islander
□ Israeli
□ Latin American
□ Lebanese
□ Mexican
□ Middle Eastern
□ Native American
□ Nigerian
□ Other
□ Patient refused
□ Puerto Rican
□ South American
□ Unknown

LANGUAGE PREFERENCE (choose one):
□ African
□ Albanian
□ Arabic
□ Armenian
□ Bangla
□ Cambodian
□ Cantonese
□ Chinese
□ English
□ French
□ French Creole
□ German
□ Greek
□ Guajarati
□ Hebrew
□ Hindi
□ Hmong
□ Hungarian
□ Italian
□ Japanese
□ Korean
□ Laotian
□ Mandarin
□ Miao Hmong
□ Navajo
□ Persian
□ Polish
□ Portuguese
□ Romanian
□ Russian
□ Scandinavian
□ Serbo-Croatian
□ Spanish
□ Tagalog
□ Thai
□ Unknown
□ Urdu
□ Vietnamese
□ Yiddish

FULL STREET ADDRESS WHERE PATIENT LIVES	CITY, STATE AND ZIP WHERE PATIENT LIVES	WHO DOES PATIENT LIVE WITH?

MOBILE PHONE NUMBER	HOME PHONE NUMBER	EMAIL ADDRESS	Would you like to communicate with the office via email?
( )	( )		☐ Yes ☐ No
Can you we send you appointment reminders via text message? ☐ Yes ☐ No	OTHER PHONE NUMBER ( )	ALTERNATE PHONE LOCATION □ WORK □ FAMILY/OTHER:_____	

EMPLOYER'S NAME	EMPLOYER'S FULL STREET ADDRESS, CITY, STATE AND ZIP	EMPLOYER'S PHONE

PRIMARY INSURANCE CARRIER'S NAME	SECONDARY INSURANCE COMPANY'S NAME

If you have Medicare and have signed up for new Medicare plans (AKA Advantage plans), it's very important that you inform us of this. Advantage Medicare plans (through commercial companies) has you opt out of Medicare and into their commercial plan. By doing this, you will have certain requirements (required pre-authorizations). Also, we don't participate with many of these plans. Therefore, it's very important to inform us if you have an Advantage-Medicare plan.

SPOUSE'S INFORMATION – ONLY NEEDED IF INSURANCE IS THROUGH SPOUSE

SPOUSE'S LAST NAME	FIRST NAME	MIDDLE I	BIRTHDATE	SOCIAL SECURITY #

ADDRESS (IF DIFFERENT THAN PATIENT)	CITY/ZIP/STATE (IF DIFFERENT THAN PATIENT)	SPOUSE'S PHONE # (IF DIFFERENT THAN PATIENT)

PRIMARY DOCTOR'S INFORMATION

PRIMARY EYE DOCTOR'S NAME	ADDRESS/CITY/STATE/ZIP	PHONE NUMBER
PRIMARY FAMILY DOCTOR/INTERNIST'S NAME	**ADDRESS/CITY/STATE/ZIP**	**PHONE NUMBER**

Medicare: I request that payment of authorized Medicare benefits be made on my behalf to Children's Eye Care (aka CEC) for services furnished me by CEC. I authorize any holder of medical information about me to relate to centers of 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 CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information or insurer or agency shown. CEC 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. **Medigap:** I understand that if a Medigap policy or other health insurance is indicated in item 9 of the CMS-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 CEC, if possible or otherwise to me. **Other insurance:** I understand that CEC maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office and that CEC has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by CEC if I belong to a plan that does not appear on the above mentioned list. **Non-covered services:** I understand that CEC's contracts with health care service plans (i.e. HMOs, PPOs) 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 services 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 CEC to obtain necessary health care services plan authorizations.

Release of information: CEC 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 CEC for reimbursement for services rendered, and (2) any health care provider for continued patient care. CEC 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, statue or regulation. A copy of this authorization may be used in place of the original.

Financial Agreement: I agree that in return for the services provided to the patient by CEC, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to CEC for payment. If an account is sent to an attorney 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 CEC. If copayments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to CEC. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill. Also, I agree to reimburse CEC the fees of any collection agency , which may be based on a percentage at a maximum of 32% of the debt, and all costs, and expenses, including reasonable attorneys' fees, we incur in such collection efforts.

Signature_____ Date_____

PATIENT NAME _____ DATE_____

IF YOU WEAR EYEGLASSES, HOW OLD WERE YOU WHEN YOU STARTED WEARING THEM?_____ HOW OLD IS THE PRESCRIPTION?_____

IF YOU WEAR CONTACTS, HOW OLD IS THE PRESCRIPTION?_____HOW MANY HOURS PER DAY DO YOU WEAR THEM?_____

IF YOU HAVE BEEN TOLD TO DO EYE EXERCISES, DESCRIBE THE EXCERCISES_____
_____
_____
_____

WHAT IS THE DATE OF YOUR LAST DILATED EYE EXAM?_____ WHO DID THE EXAM?_____

REVIEW OF SYSTEMS - PLEASE CHECK EITHER YES OR NO * DO NOT LEAVE ANY UNANSWERED

HAVE YOU RECENTLY HAD: A FEVER ☐ YES ☐ NO UNINTENTIONAL WEIGHT LOSS ☐ YES ☐ NO

DO YOU? SMOKE ☐ YES ☐ NO USE RECREATIONAL DRUGS ☐ YES ☐ NO ABUSE ALCOHOL ☐ YES ☐ NO

ARE YOU HAVING ANY OF THE FOLLOWING DIFFICULTIES:

YES NO IF YOU ANSWER YES TO THE FOLLOWING SEVEN QUESTIONS, DESCRIBE THE SYMPTOMS/ISSUES YOU'VE HAD WITH THESE ISSUES

☐ ☐ DOUBLE VISION: IF YES, WHEN DID IT BEGIN:_____
IF YOU GET DOUBLE-VISION,
☐ YOU NOTICE IT WHEN LOOKING AT FAR DISTANCES (DRIVING, WATCHING TV, PLAYING SPORTS, ETC)
☐ YOU NOTICE IT WHEN LOOKING AT NEAR RANGES (READING, USING COMPUTER, DOING FINE HANDIWORK LIKE KNITTING, ETC.)
☐ YOU NOTICE WHEN LOOKING A FAR AND NEAR RANGES
☐ YOU CLOSE YOUR EYE FOR COMFORT. IF SO, WHICH EYE: ☐ RIGHT ☐ LEFT

IF YOU GET DOUBLE VISION, DO YOU FEEL THAT IT'S (CHOOSE ONE): ☐ IMPROVING ☐ WORSENING ☐ NO CHANGE

IF YOU GET DOUBLE VISION, DO YOU HAVE PRISM(S) IN YOUR GLASSES? ☐ YES ☐ NO

YES NO
☐ ☐ DISTORTED VISION: IF YES, WHICH EYE. ☐ RIGHT ☐ LEFT
☐ ☐ EYE STRAIN
☐ ☐ MISALIGNED EYES BUT NO DOUBLE VISION
☐ ☐ EYE MISALIGNMENT IN CHILDHOOD
☐ ☐ PREVIOUS EYE MUSCLE SURGERY. IF YES, PLEASE BE CERTAIN TO DOCUMENT SURGERY IN PREVIOUS EYE SURGERY AREA BELOW

YES	NO	*HAVE YOU EVER BEEN TOLD YOU HAVE?*
☐	☐	LAZY EYE/AMBLYOPIA (SINCE CHILDHOOD)
☐	☐	CORNEAL DISEASE
☐	☐	DIABETIC EYE DISEASE
☐	☐	GLAUCOMA
☐	☐	RETINAL DETACHMENT/DISEASE
☐	☐	OTHER_____

YES	NO	*DOES/DID ANY BLOOD FAMILY MEMBER HAVE?*
☐	☐	LAZY EYE/AMBLYOPIA (SINCE CHILDHOOD)
☐	☐	CORNEAL DISEASE
☐	☐	DIABETIC EYE DISEASE
☐	☐	GLAUCOMA
☐	☐	RETINAL DISEASE
☐	☐	OTHER_____

HAVE YOU PREVIOUSLY HAD CATARACT SURGERY OR ANY EYE SURGERIES OR INJURIES (WHAT, WHEN) _____
_____
_____
_____

YES	NO	*HAVE YOU EVER BEEN TOLD YOU HAVE?*
☐	☐	CANCER
☐	☐	DIABETES - ADULT ONSET
☐	☐	DIABETES - CHILDHOOD ONSET
☐	☐	GRAVES/THYROID DISEASE
☐	☐	HEART DISEASE
☐	☐	HIGH BLOOD PRESSURE
☐	☐	HIV/AIDS
☐	☐	PROBLEMS WITH ANESTHESIA
☐	☐	MALIGNANT HYPERTHERMIA
☐	☐	TO TAKE ANTIOBIOTICS PRIOR TO DENTAL WORK OR SURGERY?

YES	NO	*HAVE YOU EVER BEEN TOLD YOU HAVE?*
☐	☐	KIDNEY DISEASE
☐	☐	LUNG BREATHING DISEASE
☐	☐	LUPUS OR MULTIPLE SCLEROSIS
☐	☐	PSYCHIATRIC DISORDER
☐	☐	PARKINSON'S DISEASE
☐	☐	RENAL FAILURE
☐	☐	RHEUMATOID ARTHRITIS
☐	☐	SKIN DISEASE
☐	☐	SLEEP APNEA AND USE OF CPAP

YES	NO	*DOES OR DID ANY BLOOD FAMILY MEMBER HAVE*
☐	☐	CANCER
☐	☐	DIABETES - ADULT ONSET
☐	☐	DIABETES - CHILDHOOD ONSET
☐	☐	GRAVES/THYROID DISEASE
☐	☐	HEART DISEASE
☐	☐	HIGH BLOOD PRESSURE
☐	☐	LUPUS OR MULTIPLE SCLEROSIS
☐	☐	PARKINSON'S DISEASE
☐	☐	OTHER_____

WHAT IS YOUR HEIGHT:_____ WHAT IS YOUR APPROXIMATE WEIGHT: _____

OTHER_____

HAVE YOU HAD ANY HEALTH-RELATED SURGERIES OR INJURIES (WHAT, WHEN) _____
_____
_____
_____

PATIENT:______________________________

CURRENT MEDICATIONS

Medication Name; Dosage & use (if known)	Reason Taking Med	FOR STAFF USE (Date & Initial)	 (Date & Initial)
		□ Reviewed – Added □ Reviewed – D/C	□ Reviewed –Added □ Reviewed – D/C
		□ Reviewed – Added □ Reviewed – D/C	□ Reviewed –Added □ Reviewed – D/C
		□ Reviewed – Added □ Reviewed – D/C	□ Reviewed –Added □ Reviewed – D/C
		□ Reviewed – Added □ Reviewed – D/C	□ Reviewed –Added □ Reviewed – D/C
		□ Reviewed – Added □ Reviewed – D/C	□ Reviewed –Added □ Reviewed – D/C
		□ Reviewed – Added □ Reviewed – D/C	□ Reviewed –Added □ Reviewed – D/C
		□ Reviewed – Added □ Reviewed – D/C	□ Reviewed –Added □ Reviewed – D/C
		□ Reviewed – Added □ Reviewed – D/C	□ Reviewed –Added □ Reviewed – D/C
		□ Reviewed – Added □ Reviewed – D/C	□ Reviewed –Added □ Reviewed – D/C
		□ Reviewed – Added □ Reviewed – D/C	□ Reviewed –Added □ Reviewed – D/C
		□ Reviewed – Added □ Reviewed – D/C	□ Reviewed –Added □ Reviewed – D/C
		□ Reviewed – Added □ Reviewed – D/C	□ Reviewed –Added □ Reviewed – D/C
		□ Reviewed – Added □ Reviewed – D/C	□ Reviewed –Added □ Reviewed – D/C
		□ Reviewed – Added □ Reviewed – D/C	□ Reviewed –Added □ Reviewed – D/C
		□ Reviewed – Added □ Reviewed – D/C	□ Reviewed –Added □ Reviewed – D/C
		□ Reviewed – Added □ Reviewed – D/C	□ Reviewed –Added □ Reviewed – D/C
		□ Reviewed – Added □ Reviewed – D/C	□ Reviewed –Added □ Reviewed – D/C