REGISTRATION INFORMATION

Thank you for assisting us in updating your personal information

Date: _____
Patient's Name: _____ Sex: [ ] M [ ] F Age_____ Date of Birth _____
Responsible Party (if a minor):_____ Relationship to Patient: _____
Social Security #:_____ [ ] SINGLE [ ] MARRIED [ ] WIDOWED [ ] SEPERATED [ ] DIVORCED
Address: _____ Home Phone: _____
City: _____ State: _____ Zip:_____

Employed by: (Responsible party if patient is a minor): _____ Occupation: _____
Business Address: _____ Business Phone: _____
Insured's Name: _____ Date of Birth _____ Social Security # _____
Employed By: _____ Occupation: _____
Business Address: _____ Business Phone: _____
How will you be paying for today's visit: [ ] Check [ ] Cash [ ] Credit Card [ ] Insurance
Do you have Medical insurance? [ ] Yes [ ] No If yes, complete below. [ ] Medicare [ ] Medicaid [ ] Workman's Comp.
Primary Insurance Carrier Name: _____Insured's DOB:_____
Contract # _____ Group # _____ Subscriber # _____
Secondary Insurance Carrier Name: _____Insured's DOB:_____
Contract # _____ Group # _____ Subscriber # _____
Do you have a vision plan? [ ] yes [ ] no Name of Plan _____ ID# _____
In case of emergency, who should be notified? _____
Phone # _____ Relationship to Patient: _____
Your Drugstore Name: _____ Phone: _____
How did you learn of our practice? ___Newspaper ___ Friend/Family
___ Radio ___ T.V.
___ Employee ___ Yellow Pages
___ OTHER _____
PURPOSE OF VISIT: _____ Date last eye exam: _____
Do you have a backup pair of glasses? [ ] YES [ ] NO Date last glasses changed: _____
Do you have prescription sunglasses? [ ] YES [ ] NO Do you wear contact lenses? [ ] Yes [ ] No

MEDICAL HISTORY

Do you have the following?

Heart Disease	( ) YES ( ) NO	Arthritis	( ) YES ( ) NO	Allergies:_____
High Blood Pressure	( ) YES ( ) NO	Thyroid Problems	( ) YES ( ) NO	_____
Diabetes	( ) YES ( ) NO	Cancer	( ) YES ( ) NO	_____
Kidney Disease	( ) YES ( ) NO	Sinus Problems	( ) YES ( ) NO	Are you taking Medications?
Lung disease	( ) YES ( ) NO	Do you smoke?	( ) YES ( ) NO	IF YES, PLEASE LIST: _____
AIDS/HIV	( ) YES ( ) NO	Do you drink?	( ) YES ( ) NO	_____
				_____
Do you have, or have you had?				_____
Glaucoma	( ) YES ( ) NO	Double Vision	( ) YES ( ) NO	_____
Cataracts	( ) YES ( ) NO	Blurred Vision	( ) YES ( ) NO	_____
Concussion	( ) YES ( ) NO	Eye Injury	( ) YES ( ) NO	If yes, explain: _____
Head Injury	( ) YES ( ) NO			_____
Amblyopia (lazy eye)	( ) YES ( ) NO			_____
Retinal disease	( ) YES ( ) NO			_____
Tired when reading	( ) YES ( ) NO	Eye Surgery	( ) YES ( ) NO	If yes, explain: _____
Spots in vision	( ) YES ( ) NO			_____
Flashes of light	( ) YES ( ) NO			_____

Other eye or vision problems? ( ) YES ( ) NO If yes, list: _____
Are there any eye diseases or blindness in your family? [ ] Yes [ ] No If yes, explain: _____

DILATION POLICY

We usually include papillary dilation as part of your examination. We may want to dilate your eyes depending on your age and the date of your last examination. Papillary dilation gives the doctor a much better view of the interior of your eyes. There are many eye diseases that cannot be discovered without viewing the eye through enlarging or dilated pupils.

The eye drops we use for this procedure may make your eyes sensitive to sunlight. We provide disposable sunglasses for your comfort and safety. This will make your drive home more comfortable. However, some patients experience blurred vision, which may last for several hours, depending on your individual eye color.

If you feel unable to drive home after dilation, you may want to phone someone to do the driving for you.

Please check one of the following:

____ I agree to have my eyes dilated today.
____ I would like to reschedule my dilation for another day.
____ I would like to discuss this procedure with the doctor before deciding.
____ I do not want my eyes dilated under any circumstances.

Signed _____ Date_____

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature for each and every claim to be submitted for myself and/or my dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

_____ herby authorizes _____
to pay and hereby assign directly to The Eye Center of North Florida all benefits, if any, otherwise payable to me for his/her services as described on the attached forms. I further acknowledge that any insurance benefits, when received by and paid to The Eye Center of North Florida, will be credited to my account in accordance with the above said assignment. **I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED.**

Signed _____ Date _____

FOR MEDICARE PATIENTS ONLY

Please be aware that the fee for refraction (the test of an eyeglass prescription) is not covered by Medicare or Medicare Supplements.

I request that payment of authorized MEDIGAP benefits be made on my behalf to the doctors of The Eye Center of North Florida for any services furnished to me by the doctors of The Eye Center of North Florida. I authorize any holder of medical information about me to release to _____ any information needed to determine these benefits or the benefits payable for related services. I understand that I do not need to provide my supplemental insurer with information concerning this Medicare claim, because my signing this authorization will cause Medicare payment information to cross over automatically.

Signed _____ Date _____

LIFETIME AUTHORIZATION

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me release to the Social Security Administration or its intermediaries or carriers any information needed for this or related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment for me.

Signed _____ Date _____