

Cortland Eye Center  
**PATIENT REGISTRATION FORM**

Today's Date: \_\_\_\_\_ Dr  Rev  Mr  Mrs  Miss  Ms   
First Initial Last

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

Race: White American Indian/Alaska Native African-American Asian Native Hawaiian/Other Pacific Islander

Sex: M F Ethnicity: Spanish/Hispanic Origin Not of Spanish/Hispanic Origin Declined/Unknown

Marital Status: Single Married Divorced Widowed Legally Separated

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Referred by: \_\_\_\_\_ Primary Physician: \_\_\_\_\_

Retired: Y N Retirement Date: \_\_\_\_\_ Pharmacy: \_\_\_\_\_ Location: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Occupation: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Insurance Information:** Please list the subscriber of the policy if other than the patient.

Primary: \_\_\_\_\_ Policy #: \_\_\_\_\_

Insurance Address: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber: \_\_\_\_\_ Plan Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Co-pay Amt: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Relationship: \_\_\_\_\_

Secondary: \_\_\_\_\_ Policy #: \_\_\_\_\_

Insurance Address: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber: \_\_\_\_\_ Plan Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Co-pay Amt: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Relationship: \_\_\_\_\_

Send Bill to: Patient o Employer o Other/Relationship

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone:# (\_\_\_\_) \_\_\_\_\_

If responsible party is other than patient-

Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_ Employer: \_\_\_\_\_

\*\*\*\*see back of form for Authorizations & Agreements\*\*\*\*

## Signature On File/Assignment of Benefits/Financial Agreement

\_\_\_\_\_  
Beneficiary Name (*Print*)

- 1. MEDICARE LIFETIME ASSIGNMENT/SIGNATURE ON FILE:** I request that payment of authorized Medicare benefits be made on my behalf to Cortland Eye Center (CEC), for services furnished to me by CEC. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services 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. 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.
- 2. MEDIGAP:** I understand that if a Medigap policy of 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 CEC, if possible, otherwise to me.
- 3. 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 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, statute or regulation. A copy of this authorization may be used in place of the original.
- 4. 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. I understand 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.
- 5. NON-COVERED SERVICES:** I understand that CEC's contracts with health care service plans (i.e., HMOs, PPOs) relate only to items and services that are "covered" by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services that 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 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 all necessary health care service plan authorizations.
- 6. 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 my account is delinquent and requires collection services, I agree to pay all collection expenses, attorney fees, and/or court costs. 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, and any other party liable to the patient, is hereby assigned to CEC. I understand and agree that any unmet deductibles are my responsibility. **I understand and agree that my insurance co-pay is due at the time of service and if not paid to CEC at the time of service, I will be charged and agree to pay a \$15.00 billing fee. I also understand that there will be a service fee applied for all payments I make that are not honored by my banking or credit/debit card Institution (bounced checks, etc.).**
- 7. TERM OF AUTHORIZATION:** This authorization shall remain in effect until I choose to revoke it.

\_\_\_\_\_  
Beneficiary Signature or Authorized Party

\_\_\_\_\_  
Date

*Note: Must Be Signed To Bill All Insurance Companies*

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

**Drug or food allergies?**

Yes  No  If YES, please list: \_\_\_\_\_

**Have you ever been treated for any medical conditions (such as diabetes, high blood pressure, arthritis, etc.)?**

Yes  No  If YES, explain: \_\_\_\_\_

**Have you had any eye disease/eye injuries/eye surgery (such as glaucoma, cataract, "lazy" eye, retinal detachment, etc.)?**

Yes  No  If YES, explain: \_\_\_\_\_

Have you ever had any other surgery? Yes  No  If YES, provide date & procedure: \_\_\_\_\_

**Do you use any eye medications?**

Yes  No  If YES, please list: \_\_\_\_\_

**Do you take any other medications?**

Yes  No  If YES, please list: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Review of Systems**

Do you **currently** have any of the following problems: **Yes** **No** If Yes, please explain:

**Eyes** (poor vision, eye pain, tearing, dry eye, redness, etc)   \_\_\_\_\_

**Constitutional** (Chronic fever, unexpected weight loss/gain, fatigue)   \_\_\_\_\_

**Ear/nose/throat problems**(hearing loss, sinus problems, sore throat, etc)   \_\_\_\_\_

**Cardiovascular/Heart problems**(high BP,chest pain, irreg. heart beat,etc)   \_\_\_\_\_

**Respiratory problems** (shortness of breath, wheezing, cough, etc)   \_\_\_\_\_

**GI problems** (heartburn, abdominal pain, diarrhea, vomiting,hernia, ulcers,etc.)   \_\_\_\_\_

**Urinary/Kidney/Bladder problems** (pain, discomfort, blood in urine, etc)   \_\_\_\_\_

**Females** (Are you pregnant? Nursing?)   \_\_\_\_\_

**Musculoskeletal** (Muscle aches, joint pain, swollen joints, arthritis)   \_\_\_\_\_

**Skin Problems** (rashes, excessive dryness, growths,etc)   \_\_\_\_\_

**Neurological** (numbness, weakness, headaches, seizures, paralysis)   \_\_\_\_\_

**Psychiatric problems** (depression, anxiety, insomnia, etc)   \_\_\_\_\_

**Endocrine problems** (Diabetes, thyroid problems, etc.)   \_\_\_\_\_

**Blood/Lymphatic problems** (anemia, leukemia, bleeding tendencies, swollen glands, etc.)   \_\_\_\_\_

**Allergic/Immunologic problems** (lupus, severe allergies, HIV, immunosuppressed etc)   \_\_\_\_\_

**Family & Social History:** (Blood relatives only – Mother, Father, Grandparent, Sibling)

**Circle any conditions that run in your family:** *Diabetes, High Blood Pressure, Blindness, Glaucoma, Macular Degeneration, Crossed/Lazy eye(s), Thyroid Disease, Other eye disease/conditions:* \_\_\_\_\_

**Who?** \_\_\_\_\_

Never Smoked Occasionally Smokes Quit Current Smoker x \_\_\_\_\_ Years How much? \_\_\_\_\_

No Alcohol Consumption  Yes Drinks Alcohol? How much? \_\_\_\_\_

Name: \_\_\_\_\_

Date: \_\_\_\_\_

In order to serve your eye care needs: Are you having any of the following eye problems or symptoms?

|                                       | Yes                      | No                       | Explanation of Problem |
|---------------------------------------|--------------------------|--------------------------|------------------------|
| Loss of vision or blurred vision      | <input type="checkbox"/> | <input type="checkbox"/> | .....                  |
| Flashes and/or floaters               | <input type="checkbox"/> | <input type="checkbox"/> | .....                  |
| Distorted vision (halos)              | <input type="checkbox"/> | <input type="checkbox"/> | .....                  |
| Loss of side vision (peripheral)      | <input type="checkbox"/> | <input type="checkbox"/> | .....                  |
| Double vision                         | <input type="checkbox"/> | <input type="checkbox"/> | .....                  |
| Dryness of eyes                       | <input type="checkbox"/> | <input type="checkbox"/> | .....                  |
| Mucous discharge of eyes              | <input type="checkbox"/> | <input type="checkbox"/> | .....                  |
| Redness                               | <input type="checkbox"/> | <input type="checkbox"/> | .....                  |
| Sandy or gritty feeling               | <input type="checkbox"/> | <input type="checkbox"/> | .....                  |
| Itching and/or burning sensation      | <input type="checkbox"/> | <input type="checkbox"/> | .....                  |
| Foreign body sensation                | <input type="checkbox"/> | <input type="checkbox"/> | .....                  |
| Excessive tearing/watering            | <input type="checkbox"/> | <input type="checkbox"/> | .....                  |
| Glare/Light sensitivity               | <input type="checkbox"/> | <input type="checkbox"/> | .....                  |
| Eye pain or soreness                  | <input type="checkbox"/> | <input type="checkbox"/> | .....                  |
| Chronic infection of eye or lid       | <input type="checkbox"/> | <input type="checkbox"/> | .....                  |
| Sties, Chalazion                      | <input type="checkbox"/> | <input type="checkbox"/> | .....                  |
| Fluctuating vision acuity (vision)    | <input type="checkbox"/> | <input type="checkbox"/> | .....                  |
| Problems with night vision or driving | <input type="checkbox"/> | <input type="checkbox"/> | .....                  |

**To assist us in appropriately prescribing and fitting your eyewear, please check the proper responses:**

**Work environment:** office setting fluorescent lighting industrial setting/construction work

**Computer use:** Hours/day spent on computer at work \_\_\_\_\_ at home use \_\_\_\_\_

**Driving:**  day night bothered by brightness/glare bothered by headlights or halos

**Hobbies:** needlework/sewing musician pilot/shooter/marksman avid reader  
stamp/coin collector, etc. woodworking gardening other \_\_\_\_\_

**Sports:** golf racquet sports skiing fishing/hunting other \_\_\_\_\_

use more than 1 pair glasses happy with current glasses problems with current glasses

**FOR OFFICE USE ONLY**

Changes + Updates to this information are noted on the exam notes.

Updated: \_\_\_\_\_  
\_\_\_\_\_