Rev 3/22

Cortland Eye Center

PATIENT REGISTRATION FORM

Today's Date: _____

_____

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

Ethnicity: Spanish/Hispanic Origin Not of Spanish/Hispanic Origin Declined/Unknown

Marital Status: Single Married Divorced Widowed Legally Separated

Sex: M F Date of Birth: ____/____ /____ Age: _____

Primary Physician: _____ Retired: Y N Retirement Date: _____

Pharmacy: _____ Location:_____

Employer: _____ Employer Phone: _____ Occupation: _____

Emergency Contact Name: _____ Phone:_____ Relationship: _____

Insurance Information: Please list the subscriber of the policy if other than the patient. **WE WILL SCAN CARDS**.

Primary: _____ Policy #: _____

Subscriber: _____ Date of Birth: _____

Relationship: _____

Secondary: _____ Policy #: _____

Subscriber: _____ Date of Birth: _____

Relationship: _____

Send Bill to: Patient ☁ Employer ☁ 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***

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Signature On File/Assignment of Benefits/Financial Agreement

_____

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 13 of the 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 13 the 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. **NOTICY OF PRIVACY PRACTICES:** Notice of Privacy Practices has been provided.

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 list.

5. **NON-COVERED SERVICES:** I understand that CEC's contracts with health care service plans 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. 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 and/or deductible is due at the time of service. I also understand that there will be a service fee applied for all payments I make that are not honored by my bank** (bounced checks, etc.)**.**

7. **TERM OF AUTHORIZATION:** This authorization shall remain in effect until I choose to revoke it.

_____ _____

Beneficiary Signature Patient or Authorized Party Date

Note: Must Be Signed To Bill <u>All</u> Insurance Companies

CEC PATIENT HISTORY RECORD Date___/___/_____

Name_____ Date of Birth _____

Please list all drug/food/environmental allergies

_____

Please circle all eye conditions you have been seen/treated for or have been in the past:
Cataracts Glaucoma Macular Degeneration Diabetic Retinopathy Amblyopia Vein/Artery Occlusions
Retinal Detachment/Retinal tears Strabismus Keratoconus Temporal Arteritis Retinitis Pigmentosa
Dry Eye Grave's Disease Macular Pucker Corneal Ulcer Metal/Foreign Body
Prism in Glasses Other _____

Please circle all eye surgeries you have had and date above surgery:

Cataract LASIK Retinal lasers Glaucoma Corneal transplant/Corneal surgeries Retinal Detachment Repair

Muscle surgery Macular Pucker surgery Lid surgery Retinal Injections

Please list all EYE medications you take, including oral, OTC or as needed medication/drops:

_____

_____

Please circle all medical conditions you are being treated for or have been treated for in the past:
Diabetes High blood pressure High Cholesterol Thyroid Stroke Heart Disease Heart Attack
Cancer Polymyalgia Rheumatica Asthma/COPD/Emphysema Myasthenia Gravis Multiple Sclerosis
Autoimmune diseases (Lupus/RA/Sjogren's/Psoriatic Arthritis/Connective Tissue Disorders)
Blood Disorders Depression Anxiety Seizures Memory Loss Other _____

Please list any medical surgeries you have had:

_____

_____

_____

Please list any medications you take, including pills, injections, OTC, as needed meds and vitamins/supplements:

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

Any past or present drug/medication addictions? ☐ **No** ☐ **Yes** _____

Smoking: ☐ Never smoked ☐ Quit ☐ Occasionally smokes ☐ Currently smokes _____per day

Vaping: ☐ Never vaped ☐ Quit ☐ Occasionally vapes ☐ Currently vapes _____per day

Alcohol: ☐ No alcohol ☐ Rarely ☐ Occasionally ☐ Frequently How much?_____

CEC PATIENT HISTORY RECORD Date___/___/_____

Name_____ Date of Birth _____

Please check box if you currently have any of the following and circle what problem(s):

☐ **Eyes** (poor vision, eye pain, tearing, dryness, redness, double vision)
☐ **Constitutional** (chronic fever, unexplained weight gain/weight loss, fatigue)
☐ **Ear/Nose/Throat** (hearing loss, sinus pain, sore throat)
☐ **Cardiovascular** (chest pain, irregular heartbeat)
☐ **Respiratory** (shortness of breath, wheezing, cough)
☐ **Gastrointestinal** (heartburn, abdominal pain, diarrhea, vomiting, hernia, ulcers)
☐ **Urinary** (pain, discomfort, frequency)
☐ **Females** (are you pregnant? Nursing?)
☐ **Musculoskeletal** (muscle aches, joint pain, swollen joints)
☐ **Skin problems** (rash, excessive dryness, lesions)
☐ **Neurological** (numbness, weakness, headache, seizures)
☐ **Psychiatric** (depression, anxiety, insomnia)
☐ **Endocrine** (diabetes, thyroid problems)
☐ **Blood/Lymphatic** (anemia, leukemia, bleeding disorders, swollen glands)
☐ **Allergic/Immunologic** (severe allergies, HIV, immunosuppressed)

Please circle the history of diagnoses for each family member that applies:

Father: Blindness Glaucoma Macular Degen Diabetes Heart Issues Hypertension Cancer Other _____

Mother: Blindness Glaucoma Macular Degen Diabetes Heart Issues Hypertension Cancer Other _____

Brother: Blindness Glaucoma Macular Degen Diabetes Heart Issues Hypertension Cancer Other _____

Sister: Blindness Glaucoma Macular Degen Diabetes Heart Issues Hypertension Cancer Other _____

Grandfather: Blindness Glaucoma Macular Degen Diabetes Heart Isses Hypertension Cancer Other _____

Grandmother: Blindness Glaucoma Macular Degen Diabetes Heart Issues Hypertension Cancer Other _____

To assist us in appropriately prescribing and fitting your eye wear, please check and fill in the proper responses:

Work environment: ☐ office setting ☐ fluorescent lighting ☐ industrial/construction work
Computer use: ☐ hours/day spent on computer at work_____ at home_____
Driving: ☐ day ☐ night ☐ bothered by brightness/glare ☐ bothered by headlights or halos
Hobbies: _____
Sports: _____
Do you: ☐ Wears contact lenses. Replacement frequency _____ Average wear time _____ ☐ Use more than 1 pair of glasses ☐ Happy with current glasses/contact lenses ☐ Problems with current glasses/contact lenses