Eyecare Registration

Date				
Name	Birthd	ate	M / F	
Address	City	State	Zip	
Telephone#	Cell#	# Work#		
Employer	Оссир	ation		
Email Address				
Please check payment plan y	you will use: a Cash a Check o	Credit Card • Insurance	;	
	Policy#			
Health Insurance:	Policy#	Group#		
Have you had any Eye Surg	ery or injuries? • Yes • No Desc	cribe		
List All Major Injuries and	Surgeries			
I have been presented with a runderstand the contents of the practices. () Accepted	notice of privacy regulations stating has notice. My signature Attests that I has notice.	now my information may ave accepted or refused t	be used and disclosed. his notice of privacy	
health informations permitted Please list the reason for refus		g services or from using o	or disclosing protected	
Patient Signature	Date			
If not signed by patient Relationship				
List names of anyone who you	u would like access or our staff to dis	scuss your records:		
(Name)	(Relationship)			
(Name)	(Relationship)	<u></u>		
(Name)	(Relationship)			

Any Special Eye or Vision Problems?								M / F			
What problems are you having with your EYES? What your EYES? Date of Last Eye Exam Date of Last Eyes Exam Date	eason for Today's \	√isit:				/	Any Special Eye or Visio	on Problems?			1
What problems are you having with your EYES? (Y) (Y) (Y) (For Doctor/Staff) Date of Last Eye Exam Doctor Doctor Phone Number Phone Number Phone Number Phone Number Phone Number Phone Number Contact Lans Use for yet Soft DW Soft DW Rigid EW History of Eye Injury / Surgery History of Eye Injury / Surgery History of Seeing Floaters Any Other Eye Diseases Alterigic to any Medications Please List: Taking any Medications Please List: Taking any Medications Please List: Taking any Medications Please List: Today I am Interested In: Classes Sunglasses Contact Lenses - Clear / Colored LASIK Personal Medications Please List: Taking any M	ccupation:						Hobbies:				
with your EYES? (*) (*) (*) (For Doctor/Staff)				Yes	No Histo	orv of Pr	resent Symptoms	Date of Last Eye	e Exam _		
Sudden Vision Loss Sudden Vision Loss Tirred Eyes'	The second secon		J9					Doctor			
Sudden Vision Loss Tired Eyes* Dyness of the Eye(s) Phome Sumber: Next Appt: Phome Number: Next Appt: Phome Number: Programmed Set of yet and	Blurred Vision– Fa	r/ Near/	Middle								
Treaf Eyes" Next Appt: Pharmscy Name: Pharmscy Name	Sudden Vis	ion Loss									
Tearing / Redness / Discharge Pharmacy Name: Pharmacy	"Tired E	yes"									
Redness / Discharge	Dryness of the	he Eye(s	;)		-51			Pharmacy Name	e:		
Eyelid Swelling	Tearing / Rednes	ss / Disc	charge								
Eyelid Swelling	Itching / Burning	/ Gritty l	Feeling					Contact Lens U	se for		year
History of Eye Injury / Surgery History of Seeing Floaters Glaucoma Any Other Eye Diseases Computer Use Hours/day: Eye Strain Yes No Solution (s) Solution Allergies Allergic to any Medications Please List: Today I am Interested in: Glasses Are you pregnant? Yes No Not Sure Personal Medical History Females: Are you pregnant? Yes No Rollergic to any Medications Please List: Today I am Interested in: Glasses Genitourinary Yes No Not Sure Personal Medical History Females: Are you pregnant? Yes No Rollergic Disease Are you nursing? Yes No Asthma Aroitety Bladder Problems Bladder Problems Bladder Problems Bladder Problems Bronchitis Br	Eyelid Sv	velling						A SAME AND	THE RESERVE		
History of Seeing Floaters Glaucoma Any Other Eye Diseases Any Other Eye Diseases Computer Use Hours/day: Eye Strain Yes No Solution(s) Solution Allergies Yes No Solution Allergies Yes No Allergic to any Medications Please List: Taking any Medications Please List: Today I am Interested in: Glasses Sunglasses Contact Lenses - Clear / Colored LASIK Females: Are you pregnant? Yes No Not Sure Are you nursing? Yes No Mental Status Yes No Genitourinary Yes No Pulmonary Yes No Depression Genitourinary Yes No Pulmonary Yes No Anxiety Genitourinary Yes No Pulmonary Yes No Cardiovascular Allergies Genitourinary Allergies Genitourinary Yes No Seizures Genitourinary Yes No Pulmonary Yes No Dither: Prostate Problems Genitourinary Allergies Genitourinary Allergies Genitourinary Yes No Dither: Prostate Problems Genitourinary Yes No Pulmonary Yes No Dither Genitourinary Yes No Dither Genitourinary Yes No Pulmonary Yes No Dither Genitourinary Yes No Descritourinary Yes No Descritourinary Yes No Descritourinary Yes No Descritour	Eye Turn/Crossed	Eye/La	zy Eye								
Age of CLs Comfortable Yes No Solution(s) Solution(solution(s) Solution(s) Solution(solution(s) Solution(solut	History of Eye In	jury / Su	rgery								
Any Other Eye Diseases Computer Use Hours/day: Eye Strain Yes No Wear Glasses Single Vision – Distance or Near Vision / Bifocals / Trifocals / Progressives Allergic to any Medications Please List: Taking any Medications Please List: Today I am Interested in: Glasses Sunglasses Contact Lenses - Clear / Colored LASIK Females: Are you pregnant? Yes No Not Sure Are you nursing? Yes No Depression Ganitourinary Yes No Pulmonary Yes No Depression Ganitourinary Yes No Depression	History of Seei	ing Float	ers								
Any Other Eye Diseases			0.0								
Computer Use								5545H3UM16445H4			
Single Vision - Distance or Near Vision / Bifocals / Trifocals / Progressives			es				Fue Steele Voe No		2007		
Allergic to any Medications	Compute	er Use						1 Diff. 1 1 Talface	-l- / D-		
Taking any Medications	Wear Gla	asses			Single Vis	ion – D	Distance or Near Vision	/ Bifocals / Trifoc	als / Pr	ogressives	
Today I am Interested in:	Allergic to any	Medicati	ons	Please L	ist:						
Mental Status Yes No Genitourinary Yes No Pulmonary Yes No	Females	S:	Are	you pregna				nursing? Yes	No		
Neurology	Mental Status	Yes	No			7.5377	-11	Pulmonary	Yes	No	
Neurology Stroke					Kidney Problems			Asthma			
					Bladder Problems			Emphysema			
Neurology					Prostate Problems	s 🗆		Bronchitis			
					Cardiovascular			Allergies			
Seizures		П			Heart Disease			Tuberculosis			
Paralysis Irregular Heart Beat Sarcoidosis Dizziness Shortness of Breath Lung Disease Double Vision High Blood Pressure Endocrine Diabetes Diabet					Enlarged Heart			Pneumonia			
Dizziness						at 🗆		Sarcoidosis			
Double Vision								Lung Disease			
Head								Endocrine			
Anemia								Diabetes			
Sinus Problems		П	П					Thyroid Disease			
Headaches								Gastrointestinal			
Migraines Sickle Cell / Trait Digestive Problems Sinus/Allergies Cancer Ulcer Disease Stress/Tension Muskuloskeletal Liver Disease Stress/Tension Arthritis Gallbladder Disease Sack Problems Pancreatic Disease Sack Problems Do you consume any alcohol products? Do you use any tobacco products? Do you consume any alcohol products? Do y	SEATTHER AND MERCHANISM							Bowel Problems			
Sinus/Allergies Cancer Ulcer Disease Sinus/Allergies Cancer Ulcer Disease Ulcer Disease Stress/Tension Muskuloskeletal Liver Disease Stress/Tension Muskuloskeletal Cancer Gallbladder Disease Describe any tobacco products? Do you consume any alcohol products? Do you consume any alcohol products? Do you consume any alcohol products? Describe any previous injuries or surgeries. Has anyone in your FAMILY (blood relatives only) had any of the following medical problems? Glaucoma Macular Degeneration Eye Disease Arthritis Lupus Diabetes Heart Disease High Blood Pressure Other:		93703							is 🗆		
Stress/Tension								9			
W/ Eye Strain											
Back Problems					C1 8 178						
Neck Problems Do you use any tobacco products? Do you consume any alcohol products? Describe any previous injuries or surgeries. Has anyone in your FAMILY (blood relatives only) had any of the following medical problems? Glaucoma Macular Degeneration Eye Disease Arthritis Lupus Diabetes Heart Disease High Blood Pressure	w/ Eye Strain						-				
Do you use any tobacco products? Do you consume any alcohol products? Describe any previous injuries or surgeries Has anyone in your FAMILY (blood relatives only) had any of the following medical problems? Glaucoma Macular Degeneration Eye Disease Arthritis Lupus Diabetes Heart Disease High Blood Pressure								rancieatic Diseas	BC []		
Describe any previous injuries or surgeries. Has anyone in your FAMILY (blood relatives only) had any of the following medical problems? Glaucoma Macular Degeneration Eye Disease Arthritis Lupus Diabetes Heart Disease High Blood Pressure			V		Neck Problems			roducts?			
Has anyone in your FAMILY (blood relatives only) had any of the following medical problems? Glaucoma Macular Degeneration Eye Disease Arthritis Lupus Diabetes Heart Disease High Blood Pressure						Do you	consume any alcohol p	roducts ?			
Glaucoma Macular Degeneration Eye Disease Attitude Eggs Charles Connect Other:			Has any	one in your				ng medical problems	i?	Blood Press	ure
Thyroid Disease Asthma Tuberculosis Sjogren's Syndrome Lung Disease Stroke Cancer Other:	Glaucoma	Maci	ular Dege	neration			man page and a second contract of		-		
	Thyroid Disease	Asth	ma Ti	uberculosis	Sjogren's Syndro	me	Lung Disease Stro	oke Cancer	Other		
Dr. Date	atient / Parent Sign	nature _					_ Dr				

Dr. Ron Sealock Financial Agreement and Consent to Treatment

The following contains important information concerning your financial responsibilities and your treatment from Dr. Ron Sealock. Please read it carefully.

Patient Name (print)	Date

- 1. FINANCIAL AGREEMENT: I understand payment for service is due in full at the time services are rendered. A 50% down payment must be made for any glasses or contact lenses at the time they are ordered, with the remaining balance due at the time of pickup. Direct ship contact lenses must be paid in full at time of order, if ordering a 1 year supply shipping is free. Because services are based on medical necessity it is impossible for our office to provide a total cost prior to evaluation. I understand Dr. Ron Sealock will bill my insurance as a courtesy, but this is not a guarantee that my insurance will pay for services rendered or materials provided. It is my responsibility to know my insurance benefits and coverage. I am responsible for all copays, deductibles, and services or materials not covered by my insurance. In the event it becomes necessary for Dr. Ron Sealock to enlist the services of a collection agency and/or legal assistance, I will be responsible for any collection expenses and reasonable fees.
- 2. NON-COVERED SERVICES: I understand that Dr. Ron Sealock's agreements with health insurance plans (i.e. HMOs, PPOs) relates only to items and service which are "covered" by the insurance plan. I accept full financial responsibility for all items or services, which determined by my insurance not to be covered, including the refraction fee.
- 3. **MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to Dr. Ron Sealock for services furnished to me by Dr. Ron Sealock. 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 to the insurer elsewhere on other approved claims forms, my signature authorizes releasing the information to the insurer or agency shown. Dr. Ron Sealock's 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.

Authorization to Bill: I have read and understood the above information and agree to comply with these terms. I authorize my insurance company to make payment directly to Dr. Ron Sealock's office. for services and/or materials rendered. I authorize Dr. Ron Sealock to release information about me or my dependents necessary to process any and all claims for reimbursement on my behalf.

Authorization to Treat: I also authorize Dr. Ron Sealock and his employees to furnish optometric care and services, including but not limited to, diagnostic tests, examinations, and other medical and/or surgical procedures, which is deemed necessary in the course of my care.