

Eyecare Registration

Date _____

Name _____ Birthdate _____ M / F

Address _____ City _____ State _____ Zip _____

Telephone# _____ Cell# _____ Work# _____

Employer _____ Occupation _____

Email Address _____

Please check payment plan you will use: ☐ Cash ☐ Check ☐ Credit Card ☐ Insurance

Vision Insurance: _____ Policy# _____ Group# _____

Health Insurance: _____ Policy# _____ Group# _____

Have you had any Eye Surgery or injuries? ☐ Yes ☐ No Describe _____

List All Major Injuries and Surgeries _____

Acknowledgement of Receipt of Privacy Notice

I have been presented with a notice of privacy regulations stating how my information may be used and disclosed. I understand the contents of the notice. My signature Attests that I have accepted or refused this notice of privacy practices.

() Accepted

() Refused. Refusal does not prohibit the provider from rendering services or from using or disclosing protected health informations permitted by law.

Please list the reason for refusal on lines below.

Patient Signature _____ Date _____

If not signed by patient

Relationship _____

List names of anyone who you would like access or our staff to discuss your records:

(Name)

(Relationship)

(Name)

(Relationship)

(Name)

(Relationship)

Name (Print) _____ Age _____ M / F Date _____

Reason for Today's Visit: _____ Any Special Eye or Vision Problems? _____

Occupation: _____ Hobbies: _____

What problems are you having with your EYES ?	Yes (✓)	No (✓)	History of Present Symptoms (For Doctor/Staff)	Date of Last Eye Exam _____ Doctor: _____
Blurred Vision— Far/ Near/ Middle				Date of Last Physical: _____
Sudden Vision Loss				Doctor: _____
"Tired Eyes"				Phone Number: _____
Dryness of the Eye(s)				Next Appt: _____
Tearing / Redness / Discharge				Pharmacy Name: _____
Itching / Burning / Gritty Feeling				Phone Number: _____
Eyelid Swelling				Contact Lens Use for _____ years
Eye Turn/Crossed Eye/Lazy Eye				Soft _____ DW _____
History of Eye Injury / Surgery				Rigid _____ EW _____
History of Seeing Floaters				Hard _____ Flex _____
Glaucoma				Type _____
Any Other Eye Diseases				Age of CLs _____
Computer Use			Hours/day: _____ Eye Strain Yes No	Comfortable 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

Personal Medical History

<u>Mental Status</u>	Yes	No	<u>Genitourinary</u>	Yes	No	<u>Pulmonary</u>	Yes	No
Depression <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Problems <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____			Prostate Problems <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Neurology</u>			<u>Cardiovascular</u>			Allergies <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Enlarged Heart <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Paralysis <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Heart Beat <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sarcoidosis <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Endocrine</u>		
<u>Head</u>			<u>Hematology</u>			Diabetes <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear Problems <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Problems <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV + <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Gastrointestinal</u>		
Headaches <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis _____ <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bowel Problems <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell / Trait <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Digestive Problems <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus/Allergies <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer Disease <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stress/Tension <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>Muskuloskeletal</u>			Liver Disease <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
w/ Eye Strain <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder Disease <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Back Problems <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pancreatic Disease <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Neck Problems <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			

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
Thyroid Disease Asthma Tuberculosis Sjogren's Syndrome Lung Disease Stroke Cancer Other: _____

Patient / Parent Signature _____ Dr. _____ Date _____

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.*

Patient or Parent/Guardian Signature