Patient Registration

Patient Name_____ Today's Date_____

Home Address_____

City_____State_____Zip Code_____

Home Phone _____Cell Phone_____

Date of Birth _____Gender: M F Marital Status: Single Married

Email _____

Race _____ Preferred Language _____

Person to notify in case of emergency_____

Phone number (s)_____Relationship_____

Primary Insurance Company_____

ID#_____Group#_____

Secondary Insurance Company_____

ID#_____Group#_____

I certify that I (or my dependent) have insurance coverage as stated above and agree to have insurance payments made directly to Central Vermont Eye Care to be applied to my account for services rendered. **I understand that I am financially responsible for all charges incurred in the event that my insurance denies payment.** I am aware there may be additional collection and/or attorney's fees if my account is referred for collection. For patients covered by Medicare the patient will be responsible for 20% of the Medicare allowable charges plus any deductibles, coinsurance and uncovered charges that apply.

_____ _____

Signature of Patient/Parent/Guardian Date

_____

Printed Name

AUTHORIZATION FOR USE OF DISCLOSURE OF PROTECTED HEALTH INFORMATION:

I authorize my physician and/or administrative and clinical staff of Central Vermont Eye Care to disclose general medical information and other protected health information to the following persons and/or entities listed below. If no one is listed below, protected health care information will not be disclosed except in those situations described in the Notice of Privacy Practices.

Name and relationship of person(s) who you wish to allow access: (e.g., your spouse, son, daughter, friend).

Name of Person or Entity	Relationship

_____ _____

Signature Date

_____

Printed Name

CENTRAL VERMONT
EYE CARE

NOTICE OF MEDICARE BILLING AND PRIVACY PRACTICES

NAME: _____ DOB: _____

MEDICARE ID NUMBER: _____

SECONDARY INSURANCE: _____

SECONDARY INSURANCE ID #: _____ GROUP #_____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Central Vermont Eye Care for any services furnished to me by their providers. I authorize any holder of medical information about me to release to the Health Care Financing Administration and it's agents any information needed to determine these benefits payable to 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 coverage is indicated in Item 9 of the CMS 1500 claim form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare-assigned cases, Central Vermont Eye Care agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is only responsible for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

An example of a non-covered charge is the eye refraction fee. If a refraction is performed, the $40.00 charge is payable at the time of visit. For more information about refractions, please see our posted policy.

Available for viewing at the front desk is a six page notice of privacy practices as mandated by the Health Insurance Portability and Accountability Act of 1996, otherwise known as HIPAA. This notice describes how medical information about you may be used and disclosed, how you can get access to it, and lists your rights under this law.

I have read and understand the above statements regarding Medicare and the privacy practices used by Central Vermont Eye Care.

_____ _____

Signature of patient/parent/guardian Date

_____

Printed Name

Name: _____

Date of Birth: _____

Past Eye Problems

_____
_____
_____
_____
_____

Past Medical History

_____
_____
_____
_____
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_____
_____
_____
_____
_____

Past Surgical History

_____
_____
_____
_____
_____
_____
_____

Primary Care Physician: _____

Preferred Pharmacy: _____

_____

Prior Eye Surgery

_____
_____
_____
_____
_____

Family History

condition		*family member*
Cataracts	Y / N	_____
Glaucoma	Y / N	_____
Macular Degeneration	Y / N	_____
Crossed/Lazy Eye	Y / N	_____
Retinal Detachment	Y / N	_____
Diabetes	Y / N	_____

Social History

Do you consume alcohol? Y / N
Do you use recreational drugs? Y / N

If **YES**, please specify: _____

Do you *currently* smoke cigarettes? Y / N

If **NO**, did you *previously* smoke? Y / N

If so, when did you quit? _____

Eye Medications

_____
_____
_____
_____
_____

Other Medications

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Allergies

_____
_____
_____
_____
_____

Review of Systems: Please Circle All That Apply

Cardiovascular	HEENT	Musculoskeletal	Respiratory	Blood Pressure
chest pain	dizziness	back pain	cough	good BP control
irregular heart beat	hearing loss	joint pain	trouble breathing	borderline BP control
shortness of breath	hoarseness	muscle aches	wheezing	poor BP control
	ringing in ears	stiffness		unknown BP control
	sore throat	swelling		

Constitutional	Hematologic	Neurologic	Skin	Diabetic Control
fatigue	bleeding	balance problems	hair loss	good DM control
fever	bruising	headache	rash	borderline DM control
night sweats	tender nodes	numbness	skin lesions	poor DM control
weakness		tingling		unknown DM control
weight loss				

Genitourinary	Metabolic	Psychiatric	Allergy	Pregnancy
genital discharge	cold intolerance	anxiety	itching	first trimester
genital lesions	excessive hunger	depression	hives	second trimester
painful urination	excessive thirst	insomnia	chronic runny nose	third trimester
urgency	frequent urination	irritability	seasonal allergies	nursing
	heat intolerance	nervousness		

Other Problems: Please Specify Below