

## 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

## NOTICE OF FINANCIAL AND PRIVACY POLICIES

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 its 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 CMS 1500 claim form or elsewhere on other approved claim forms or electronically submitted claims, my signature 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 ask for our policy at the front desk.

Available for viewing at the front desk is a notice of privacy practices as mandated by the Health Insurance Portability and Accountability Act of 1996, otherwise known as HIPPA. 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 understand the above statements regarding the financial policy and privacy practices used by Central Vermont Eye Care.***

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

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

Primary Care Physician: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_

**Past Eye Problems**

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

**Prior Eye Surgery**

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

**Eye Medications**

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

**Past Medical History**

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

**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	_____

**Other Medications**

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

**Past Surgical History**

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

**Social History**

Do you consume alcohol?      Y/N

Do you use recreation 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? \_\_\_\_\_

**Allergies**

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

**Review of Systems: Please circle all that apply**

<b>Cardiovascular</b>	<b>HEENT</b>	<b>Musculoskeletal</b>	<b>Respiratory</b>	<b>Blood Pressure</b>
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		
<b>Constitutional</b>	<b>Hematologic</b>	<b>Neurologic</b>	<b>Skin</b>	<b>Diabetic Control</b>
fatigue	bleeding	balance problems	hair loss	good DM control
fever	bruising	headaches	rash	borderline DM control
night sweats	tender nodes	numbness	skin lesions	poor DM control
weakness		tingling		unknown DM control
weight loss				
<b>Genitourinary</b>	<b>Metabolic</b>	<b>Psychiatric</b>	<b>Allergy</b>	<b>Pregnancy</b>
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: Specify Below**