

Patient Registration & Insurance Form

Union City Eye Care, p.c.

Salutation (Mr,Mrs,etc)	Suffix (Jr,Sr,etc)	Address	
First Name	Preferred Name	City	
Last Name	DOB	State	Zip
Middle Name	SS#	<input type="checkbox"/> Male	<input type="checkbox"/> Female

Preferred Phone <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell	Email Address
Home #	
Work #	
Cell #	PCP – Primary Care Provider (primary doctor)

Language Spoken	Dominant Eye <input type="checkbox"/> Unknown <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Ambicocular
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	Dominant Hand <input type="checkbox"/> Unknown <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Ambidextrous

Employment Status Employed Full Time Employed Part Time Unemployed Retired
 Disabled Homemaker Active Military Student

Employer _____ Position _____

Employer Address _____ City _____ State _____ Zip _____

Primary Reason for Today's Visit (check 1) <input type="checkbox"/> no complaints or concerns-wellness check <u>OR</u> <input type="checkbox"/> list reason – be specific, but brief _____	List Immediate Family Members Living in Your Household	Husband, Wife, Parent, Child, Other	Date Of Birth

Primary Medical (not vision) Ins. Co.	Secondary Medical (not vision) Ins. Co.
Policy/ID #	Policy/ID #
Policy Holder Name	Policy Holder Name
Relationship	Relationship
Policy Holder Date of Birth	Policy Holder Date of Birth

**Note: Space only allows for 1 person to accompany the patient to the exam room.
 Silence cell phones when in the exam rooms, please.**

Financially Responsible Person / Guarantor(Complete this section if patient is not the guarantor.)

Name	Social Security #
Relationship to Patient	Employer
Date of Birth	Position
Address (if different)	Employer Address
Telephone (if different)	

Dilated Retinal Exam

Dilating the pupils allows for a more thorough eye health examination. Many eye diseases have no pain or symptoms, so a periodic dilated exam is highly recommended. There is no extra charge for dilation when performed at time of comprehensive examination. If we must schedule dilation on another date, additional fees may apply.

The eye drops used in dilation may make reading difficult and increase light sensitivity for several hours. We provide "disposable" sunglasses if needed.

I request dilation **I prefer not to be dilated**

Optional Screening Tests

The following tests are recommended to enhance your eye care evaluation, but add time and cost to the exam; therefore each patient should take a role in deciding what level of care they receive. These optional evaluations are considered well patient care unless they are done to evaluate for a specific disease, and are over and above the standard of care of routine eye examinations. **As a result, they are not covered by insurance.**

Visual Field Screening	Screens for neurologic disorders that may affect the visual system.	<input type="checkbox"/> YES (accept) Fee \$15.00	<input type="checkbox"/> NO (decline)
Retinal Photography	Allows evaluation & comparison of the retina, macula, optic nerve, and blood vessels when repeated periodically.	<input type="checkbox"/> YES (accept) Fee \$15.00	<input type="checkbox"/> NO (decline)

Print Patient Name
Signature of Patient, Parent, or Guardian (must be over 18)
Relationship to Patient
Date

Pt. Name: _____ Date: _____

MEDICAL HISTORY: (PLEASE CHECK ALL THAT APPLY TO YOU PERSONALLY)

Constitution:

- Developmental Disabilities
- Cancer
- Fatigue Syndrome
- Other: _____

ENT:

- Hearing Loss
- Sinusitis
- Dry Mouth
- Laryngitis
- Other: _____

Neurologic:

- Multiple Sclerosis
- Epilepsy
- Cerebral Palsy
- Tumor
- Stroke/CVA
- Migraine
- Autism Spectrum Disorder
- Other: _____

Psychological:

- Depression
- Attention Deficit
- Anxiety Disorder
- Bipolar Disorder
- Other: _____

Cardiovascular:

- High Blood Pressure
- Stroke/CVA
- Heart Disease
- Vascular Disease
- Congestive Heart Failure
- Other: _____

Respiratory:

- Cigarette Smoker
- Asthma
- Bronchitis
- Emphysema
- Chronic Obstruction-COPD
- Sleep Apnea
- Other: _____

GI:

- Crohn's
- Colitis
- Ulcer
- Acid Reflux
- Celiac Disease
- Other: _____

Genital/Urinary:

- Kidney Disease
- Prostate Disease/Cancer
- STD
- Benign Prostate Hypertrophy
- Pregnant
- Nursing
- Herpes
- Chlamydia
- Other: _____

Musculoskeletal:

- Osteoarthritis
- Arthritis
- Fibromyalgia
- Muscular Dystrophy
- Ankylosing Spondylitis
- Osteoporosis
- Gout
- Other: _____

Integumentary:

- Eczema
- Rosacea
- Psoriasis
- Herpes Simplex/Cold Sores
- Herpes Zoster/Shingles
- Other: _____

Endocrine:

- Type 2 Diabetes
- Type 1 Diabetes
- Thyroid Dysfunction
- Hormonal Dysfunction
- Other: _____

Hematologic/Lymphatic:

- Anemia
- Large-Volume Blood Loss
- Ulcer
- High Cholesterol
- Other: _____

Allergy/Immune System:

- Drug Allergies
- Environmental Allergies
- Rheumatoid Arthritis
- Lupus
- Sjogren's Syndrome
- Other: _____

<u>Medications (including eye medications)</u>	<u>Milligrams</u>	<u>Dosage (how many, how often?)</u>

<u>Medication Allergies</u>	<u>Reaction</u>	<u>Other Allergies</u>	<u>Reaction</u>

PAST OCULAR HISTORY: (PLEASE CHECK ALL THAT APPLY TO YOU PERSONALLY.)

- | | | | |
|---|--|---|---------------------------------------|
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Eye Surgery | <input type="checkbox"/> Amblyopia | <input type="checkbox"/> Eye Injury |
| <input type="checkbox"/> Glaucoma Suspect | <input type="checkbox"/> Patching | <input type="checkbox"/> Retinal Degeneration | <input type="checkbox"/> Dry Eye |
| <input type="checkbox"/> Cataract | <input type="checkbox"/> Inflammatory Disorder | <input type="checkbox"/> Retinal Hole | <input type="checkbox"/> Nystagmus |
| <input type="checkbox"/> Age Related Macular Degeneration | <input type="checkbox"/> Strabismus-Crossed or Turned Eyes | <input type="checkbox"/> Retinal Detachment | <input type="checkbox"/> Other: _____ |
| | | <input type="checkbox"/> Keratoconus | |

Alcohol Use: Yes No **Amount:**

Tobacco Use: Yes No **Preference:** Cigars Cigarettes Pipe Smokeless Other

Amount:

Smoking Status:	<input type="checkbox"/> Current Every Day Smoker	<input type="checkbox"/> Former Smoker	<input type="checkbox"/> Heavy Smoker
	<input type="checkbox"/> Current Some Days Smoker	<input type="checkbox"/> Never Smoked	<input type="checkbox"/> Light Smoker

Hobbies:

FAMILY HISTORY:
In your immediate family, is there a history of any of the following? Check (√) any that apply.

Family Medical History:	Family Ocular History:	
<input type="checkbox"/> None	<input type="checkbox"/> None	<input type="checkbox"/> Severe myopia
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Cataract	<input type="checkbox"/> Severe hyperopia
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Strabismus
<input type="checkbox"/> Cancer	<input type="checkbox"/> Glaucoma suspect	<input type="checkbox"/> Retinal Detachment
<input type="checkbox"/> Thyroid	<input type="checkbox"/> Macular degeneration	<input type="checkbox"/> Dry Eye
<input type="checkbox"/> Other	<input type="checkbox"/> Amblyopia	<input type="checkbox"/> Nystagmus
	<input type="checkbox"/> Other	

UNION CITY EYE CARE APPOINTMENT POLICY

Union City Eye Care is committed to providing all of our patients with exceptional care. When you schedule an appointment with us, we set aside enough time to provide you with the highest quality care. We will begin to prepare for your visit several days before you arrive by confirming your appointment, verifying your insurance, and preparing any necessary documents. To insure maximum access to eye care services for all of our patients, please be aware of the following appointment policy. **Please initial each blank and sign at the bottom of the page.**

Definition of a "No Show" Appointment – any scheduled visit in which the patient either:

- Does not show up
- Cancels with less than 24 hours notice
- Arrives more than 15 minutes late and is consequently unable to be seen. _____

Impact of a "No Show" Appointment – "No Show" appointments have a significant impact on our practice and the healthcare we provide to our patients. When a patient "no shows", it:

- Potentially jeopardizes the health of the "no show" patient
- Is unfair (and frustrating) to other patients who are needing a sooner appointment
- Disrespects not only the doctor's time, but also the time of the entire staff _____

To Avoid Getting a "No Show"

- Confirm your appointment -- We will contact you by text and / or email 1 week prior to your scheduled appointment and again the day before your visit. Please confirm by following the directions. If you do not use text or email, you will receive a phone call, possibly an automated call that will direct you on how to confirm. If we have to leave a voice mail message, please call ASAP to confirm.
- Give 24 Hours Notice if You Need to Cancel or Reschedule
When you need to cancel or reschedule, we ask that you contact us no later than 24 hours prior to your appointment. This allows enough time to offer your appointment to another patient.

****We understand that there are times when you must miss due to an emergency. If it is less than 24 hours before your appointment, please give us the courtesy of a phone call.** _____

Consequences of "No Show" Appointments

- If you miss 2 appointments, you will not be able to schedule another appointment.
- You may be able to be seen on a time available, walk in basis only, but must realize that appointed patients and emergencies will take priority. _____

Late Arrivals – If you arrive more than 15 minutes late for your scheduled visit, you will be given the option to:

- Reschedule your appointment
- Wait to see if an opening occurs that will allow you to be seen _____

Back to Back Appointments

- If we schedule back to back appointments for 2 children or 1 adult and 1 child, we ask that an **extra** adult be present to accompany one child to their appointment.
- Back to back appointments require a larger block of reserved time and if missed without 24 hours notice, you will **no longer** be able to schedule back to back appointments. _____

Extra Family Members Present for Appointments – Please refrain from bringing extra family members because:

- There is not room for them in the exam room
- Extra noise and movement may impede the exam _____

Cell Phones MUST be silenced during an examination!!! _____

I have read and understand the Union City Eye Care Appointment Policy as described above

Print Patient Name

Signature of Patient or Guardian

Date