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#	☐ Male ☐ Female

Preferred Phone ☐ Home ☐ Work ☐ Cell		Email Address
Home #		
Work #		PCP – Primary Care Provider (primary doctor)
Cell #		

Language Spoken	Dominant Eye ☐Unknown ☐ Right ☐ Left ☐ Ambiocular
Marital Status ☐ Single ☐ Married	Dominant Hand ☐Unknown ☐ Right ☐ Left ☐ Ambidextrous

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

Employer	Position		
Employer Address	City	State	Zip

Reason for Today's Visit (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.

You may receive access to your records electronically, upon request.

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.	☐ YES (accept) Fee $15.00	☐ NO (decline)
Retinal Photography	Allows evaluation & comparison of the retina, macula, optic nerve, and blood vessels when repeated periodically.	☐ YES (accept) Fee $15.00	☐ 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:_____

Medications

Eye Drops / Medications

Medication Allergies	Reaction	Other Allergies	Reaction

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

□ Glaucoma	□ Eye Surgery	□ Amblyopia	□ Eye Injury
□ Glaucoma Suspect	□ Patching	□ Retinal Degeneration	□ Dry Eye
□ Cataract	□ Inflammatory Disorder	□ Retinal Hole	□ Nystagmus
□ Age Related Macular Degeneration	□ Strabismus-Crossed or Turned Eyes	□ Retinal Detachment □ Keratoconus	□ Other:_____

Alcohol Use: □ Yes □ No **Amount:**

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

Amount:

Smoking Status:	□ Current Every Day Smoker □ Current Some Days Smoker	□ Former Smoker □ Never Smoked	□ Heavy Smoker □ Light Smoker

Hobbies:

FAMILY HISTORY:

In your immediate family, is there a history of any of the following? Check (√) any that apply.
*** (father, mother, brother, sister, son, daughter)

Family Medical History:	Family Ocular History:	
□ None	□ None	□ Other
□ High blood pressure	□ Cataract	
□ Diabetes	□ Glaucoma	
□ Cancer	□ Macular degeneration	
□ Thyroid	□ Amblyopia	
□ Other	□ Strabismus	
	□ Retinal Detachment	

UNION CITY EYE CARE, p.c.

Alan K. Bugg, O.D. **Bradley A. Bugg, O.D.**

Name	**Today's Date**
Social Security #	**Date of Birth**

As a courtesy to our patients, we will file insurance and accept assignment of benefits pending authorization from the patient's insurance plan. Having insurance is not a substitute for payment. It is the patient's responsibility to pay in advance for the deductible, coinsurance, or any other balances not paid by insurance. The patient is responsible for providing accurate information to file on any coverage they may have. If false or incomplete information is provided, the patient will be responsible for payment.

SIGNATURE ON FILE

I certify that the insurance information I have provided is true and correct. I authorize Union City Eye Care, pc to act as my agent in helping me obtain payment of my insurance benefits, and I authorize payment of these benefits to Union City Eye Care, pc or it's physicians on my behalf for any services and materials received. 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 for related services. If I have other health insurance coverage (as indicated in Item 9 of the HCFA-1500 claim form or electronically submitted claim), my signature authorizes release of medical information to the insurer and authorizes Union City Eye Care, pc to act as my agent. This authorization remains in effect until revoked in writing. The term "insurance" as used in this agreement refers to all third party payers applicable for the designated patient. This includes, but is not limited to Medicare, Medigap or supplemental insurances, Medicaid, TennCare, private insurance and/or vision plans.
Also, I authorize doctors and staff of UCEC,pc to share medical / personal information with other physicians / medical facilities in order to provide continuity of care.

Patient or Legal Guardian _____ Relationship (if applicable) _____ Date _____

FINANCIAL RESPONSIBILITY

By signing this statement, you agree to be financially responsible for all charges. Balances due must be paid before materials are dispensed. A service charge of 1.5% per month (or minimum statement fee) will be added to all overdue accounts. Financing of purchases may be available from Care Credit, an independent financing company. If we do not receive payment in a timely fashion, your account may be referred to an outside firm for collection. If this occurs, you will be responsible for all collection and attorney fees. Returned checks will be assessed a $25 fee.

Patient or Legal Guardian _____ Relationship (if applicable) _____ Date _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information on how we may use and disclose protected health information. At Union City Eye Care, we take your privacy seriously and strive to maintain a high level of vigilance. Union City Eye Care's Privacy Policy is available for viewing if requested. By signing below, I attest that I have received or have been given the opportunity to receive a copy of the privacy policies.

Patient or Legal Guardian _____ Relationship (if applicable) _____ Date _____

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