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
Home #		Emergency Contact Name Relationship Emergency Contact #
Work #		
Cell #		Primary Medical Doctor

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 –Check One:

____**Routine Wellness Eye Exam - NO MEDICAL COMPLAINTS**

____**Diabetic Eye Exam**

____**I have medical complaints. Explain:**

____

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: * Patients under age 18 must be accompanied by an adult. All other visitors must remain in the waiting room. (Exceptions made for physical / cognitive necessity)

*** Silence cell phones when in the exam rooms, please.**

Financially Responsible Person / Guarantor (Complete this section if patient is **NOT** the guarantor. Minor children MUST have an ADULT 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 recommended. (Highly recommended for diabetic patients)

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

☐ **I choose to dilate today** ☐ **I choose not to dilate today**

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 disorders that may affect the visual system such as glaucoma and other neuro-ophthalmic pathologies.	☐ YES Fee due of $15.00	☐ NO (decline)
Retinal Photography	Allows evaluation & comparison of the retina, macula, optic nerve, and blood vessels when repeated periodically.	☐ YES Fee due of $15.00	☐ NO (decline)

Prescription Signed Acknowledgement

I understand that my eye doctor will provide me with a copy of my eyeglass and/or contact lens prescription at the completion of my exam. With my signature below, I provide consent for my prescription(s) to be delivered electronically through my personal health record. In addition, a paper copy of either will be provided upon request.

Patient Name (print) :
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
- □ Glaucoma Suspect
- □ Cataract
- □ Age Related Macular Degeneration
- □ Eye Surgery
- □ Patching
- □ Inflammatory Disorder
- □ Strabismus-Crossed or Turned Eyes
- □ Amblyopia
- □ Retinal Degeneration
- □ Retinal Hole
- □ Retinal Detachment
- □ Keratoconus
- □ Eye Injury
- □ Dry Eye
- □ Nystagmus
- □ 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. Britton M. 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 ____________

APPOINTMENT AND "NO SHOW" POLICY

We at Union City Eye Care, p.c. are dedicated to delivering the highest level of personalized care to each of our patients. When an appointment is made, this is "your time" specifically set aside to engage with the doctor. To ensure maximum access to eye care services for all of our patients, please be aware of the following appointment policy:

CELL PHONES MUST BE SILENCED DURING AN EXAMINATION!!!
(This includes any accompanying parent or assistant present in the exam room!)

- **Do not bring extra people to your appointment.** (Exceptions made for physical/cognitive necessity.) Adult patients, please refrain from bringing extra family members (**specifically babies and small children**) to your appointment. They will not be allowed in the exam room due to space issues; additionally, the extra noise and movement can create distractions and delays in completing your exam. Our doctors want to give each patient the focused time and attention he or she deserves.
  *Parents/guardians of minor patients – **one adult must accompany one minor child (under age 18) to the exam room**. All other children must remain in the waiting room. If the child is of an age requiring supervision, please bring an additional adult to sit with them, as they will not be allowed to go back in the exam room with you and the patient.

- **Please confirm your appointment.**
  Appointments may be confirmed by one of three ways. The easiest way is by simply typing "yes" in response to a reminder text message you will receive one week prior to your appointment. A second text will be sent again two days prior to the appointment, as a reminder, as well. The second method to confirm is by e-mail. Simply click on the hot-link in the e-mail and you're all set. Finally, you may call our office at 731-885-1049, to confirm.

- **Arriving late to your appointment**
  The impact of a late arrival has the trickle-down effect of delaying other patient's appointments throughout the day. If you arrive for your scheduled visit 15 minutes late, you will be given two options. 1) You may reschedule your appointment for another day. 2) You may take a seat to see if an opening comes available and we will try to "work in" a time for you. This is not a guarantee you will be seen the same day.

- **Back to back appointments**
  If we schedule back to back appointments for two minor children or one adult and one minor 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 time, therefore if missed without giving 24 hours notice, you will **NO LONGER** be able to schedule back to back appointments.

- **"NO-SHOW APPOINTMENTS"**
  A "NO-SHOW" appointment is defined as any appointment that you scheduled that you:
  - Didn't show up - Canceled with less than 24 hours notice - Arrived more than 15 minutes late

No-show appointments are frustrating and consequential for everyone as they are unfair to patients needing sooner appointments, potentially dangerous to the health of the patient who misses the appointment, and disrespectful to the doctor's and clinic staff's time.

Consequences of "No-Show" Appointments:

If you "no-show"(as defined above) two (2) appointments, you will no longer be able to make scheduled appointments. You will instead be placed on a "WORK-IN ONLY" basis, meaning you would have to call on a day you would be able to come to an appointment, and we will "work you in", if we have an opening with your doctor on that specific day.

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

I have read and understand the Union City Eye Care Appointment/No-Show policy as described above.

____________________ ____________________ ____________

Signature of Patient or Guardian | **Print** Patient Name | Date