**PATIENT REGISTRATION (PLEASE PRINT)**

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| CAREFULLY READ AND COMPLETE ALL PAGES **PATIENT INFORMATION:** | **TODAY’S DATE:** |
| PATIENT’S NAME: DR MR MS MISS MRS |  **NEW PATIENT** **RETURNING PATIENT****DATE LAST EXAM:\_\_\_\_\_\_\_** | **AGE:** | **BIRTH/DATE:** |
| **FIRST NAME** | LAST NAME |
|  |  |  **M** **F** |  **SINGLE MARRIED OTHER** **EMPLOYED STUDENT**  |
| **STREET ADDRESS:** | **EMAIL:** |
| **CITY:** | **STATE:** | **ZIP CODE:** |
| **PATIENT’S SS #:** | **IF STUDENT WHAT GRADE:** | **Occupation:** | **Employer:** |
| **HOME PHONE:**  | **BUSINESS PHONE:** | **CELL PHONE:** |

 **IF PATIENT IS A MINOR WHO IS RESPONSIBLE FOR THIS PATIENT**

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| **PARENT OR GUARDIANS NAME: DATE OF BIRTH:** |
| **DOES PATIENT WEAR GLASSES: YES NO**  |  **ALL THE TIME OCCASIONALLY READING DRIVING TV COMPUTER** |
| **DOES PATIENT WEAR CONTACTS: YES NO** | **ARE YOU INTERESTED IN REFRACTIVE SURGERY: YES NO** |
| **RACE:** American Indian or Alaska Native Asian  Black or African American White No Answer Other:  | **ETHNICITY:**  Hispanic or Latino Not Hispanic or Latino No Answer |
| PREFERRED LANGUAGE: English Spanish Other: |
| **PLEASE PRESENT YOUR CURRENT MEDICAL INS AND VISION INS CARDS AT EACH VISIT** |

\*\* PLEASE NOTE THAT YOUR INSURANCE MAY NOT COVER ANY OR ALL OF THE EXAM, GLASSES OR CONTACT LENSES AND YOU ARE RESPONSIBLE IF PAYMENT IS DENIED AS WELL AS ANY CO-INSURANCE, DEDUCTIBLES, AND CO-PAYMENTS. ALSO YOUR INSURANCE MIGHT NOT ALLOW US TO DO A MEDICAL AND A VISION EXAM ON SAME DAY. \*\*

 **CAREFULLY CHECK THE REASON FOR THIS VISIT (IS IT MEDICAL OR VISION):**

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| **🞎 MEDICAL Eye Exam** **CHECK BELOW THAT APPLIES TO PATIENT****🞎** **Red Eye 🞎 Discharge from eye****🞎 Eye Pain 🞎 Watery Eyes****🞎 Sandy/Gritty feeling****🞎 Itchy / Burning Eyes****🞎 Diabetes 🞎 Glaucoma****🞎 Cataracts 🞎 Retinal Disease** **🞎 Floaters or Spots****🞎 Flashes / Bolts of light** **🞎 Swollen Eye Lids:****🞎 Other (please explain):****READ BELOW ABOUT THIS TYPE OF EXAM:**This is usually considered under your medical insurance coverage. Medical copay/deductibles or FEES may apply.The office staff will advise you. |  **ROUTINE or ANNUAL****VISION/EYEGLASS EXAM****(I need new glasses, blurry vision)**  **Blurry Vision (with present glasses):** **Distance Near Both** **Blurry Vision (without glasses):** **Distance Near Both****READ BELOW ABOUT THIS TYPE OF EXAM:**This is usually considered under your vision insurance coverage. Copay and Other Fees may applyThe office staff will advise you. |  **Contact lens evaluation and fitting****READ BELOW ABOUT THIS TYPE EXAM:**This usually requires additional fees.If might be fully covered, partially covered or not covered by your insurance. Copays and or other fees may apply **FEES VARY depending on the complexity of your eye condition.**You will be advised by the office staff or Dr. Rose.  |
| **DRY EYE DISEASE QUESTIONS:****FILL THIS SECTION IF EVALUATING DRY EYE**This is under MEDICAL COVERAGE and depending on what you check off below might require additional FEES, special testing and evaluation. You will be advised.🞎 Watery/Tearing eyes🞎 Itchy / Burning eyes🞎 Scratchy, Sandy or Gritty Feeling🞎 Contact Lens Discomfort🞎 Glare/Light Sensitivity🞎 Eye pain/soreness🞎 Dry Eye Feeling🞎 Tired eyes/ eye fatigue🞎 Stringy mucus discharge🞎 Redness |
| 🞎 Crossed Eye (Strabismus) |
| 🞎 Double Vision |
| 🞎 Other (please explain): |
|  **MEDICAL Eye Exam follow up:** | 🞎 Headaches:  |
|  DIABETIC EYE EXAMINATION |
|  RETINAL & MACULA Eye Evaluation |  Cataract Pre Op or Post Op: |
|  CATARACT Evaluation | 🞎 LOST/BROKEN GLASSES |
|  GLAUCOMA Evaluation  |  |
| **CHIEF or OTHER COMPLAINTS:** |

**PATIENT’S MEDICAL HISTORY (Review of Systems)**

**Name of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Height: \_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_ Blood Pressure: \_\_\_\_/\_\_\_\_\_ No Answer**

**\*\*\*\*\*\*\*\*\*\* CIRCLE (Yes or No) ALL THAT APPLIES TO PATIENT \*\*\*\*\*\*\*\*\***

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| **ALLERGIC/IMMUNOLOGIC** | **MUSCULOSKELETON** | **CARDIOVASCULAR** |
| **Yes** | **No** | **Drug Allergy:** | **Yes** | **No** | **Fibromyalgia** | **Yes** | **No** | **Heart Disease** |
| **Yes** | **No** | **Environmental allergy:**  | **Yes** | **No** | **Muscular Dystrophy** | **Yes** | **No** | **Hypertension/High Blood Pressure** |
| **Yes** | **No** | **Rheumatoid arthritis** | **Yes** | **No** | **Osteoarthritis** | **Yes** | **No** | **Stroke** |
| **Yes** | **No** | **Lupus** | **Yes** | **No** | **Ankylosing Spondylitis** | **Yes** | **No** | **Vascular disease** |
| **Yes** | **No** | **Other:**  | **Yes** | **No** | **Sarcoidosis** | **Yes** | **No** | **High Cholesterol** |
|  |  |  | **Yes** | **No** | **Other:**  | **Yes** | **No** | **Other:**  |

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| **GASTROINTESTINAL** | **NEUROLOGICAL** | **CONSTITUTIONAL SYMPTOMS**  |
| **Yes** | **No** | **Crohn’s** | **Yes** | **No** | **Multiple sclerosis** | **Yes** | **No** | **Developmental disability** |
| **Yes** | **No** | **Colitis** | **Yes** | **No** | **Epilepsy** | **Yes** | **No** | **Other:** |
| **Yes** | **No** | **Ulcer** | **Yes** | **No** | **Alzheimer/Dementia** |  |  |  |
| **Yes** | **No** | **Other:** | **Yes** | **No** | **Parkinson** |  |  |  |
|  |  |  | **Yes** | **No** | **Other:**  |  |  |  |

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| **GENITOURINARY** | **PSYCHIATRIC** | **EAR, NOSE , THROAT, MOUTH**  |
| **Yes** | **No** | STD viral herpetic, Chlamydia | **Yes** | **No** | **Depression** | **Yes** | **No** | **Upper respiratory tract infection** |
| **Yes** | **No** | Other:  | **Yes** | **No** | **Panic Disorder** | **Yes** | **No** | **Earache** |
|  |  |  | **Yes** | **No** | **Schizophrenia** | **Yes** | **No** | **Other:**  |
|  |  |  | **Yes** | **No** | **Other:**  |  |  |  |

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| **HEMATOLOGIC/LYMPHATIC**  | **RESPIRATORY** | **ENDOCRINE** |
| **Yes** | **No** | **Anemia** | **Yes** | **No** | **Asthma** | **Yes** | **No** | **Diabetes Type II** |
| **Yes** | **No** | **Leukemia** | **Yes** | **No** | **Bronchitis** | **Yes** | **No** | **Diabetes Type I** |
| **Yes** | **No** | **Other:** | **Yes** | **No** | **Emphysema** | **Yes** | **No** | **Thyroid Disease** |
|  |  |  | **Yes** | **No** | **Other:**  | **Yes** | **No** | **Hormonal dysfunction** |
|  |  |  |  |  |  | **Yes** | **No** | **Other:**  |

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| **INTEGUMENTARY (Skin)** | **EYES**  | **OTHER HEALTH CONDITIONS** |
| **Yes** | **No** | **Eczema** | **Yes** | **No** | **Glaucoma** |  | **Cancer: Type: \_\_\_\_\_\_\_\_\_\_\_\_ Status: \_\_\_\_\_\_** |
| **Yes** | **No** | **Rosacea** | **Yes** | **No** | **Cataracts** |  | **Blindness** |
| **Yes** | **No** | **Psoriasis** | **Yes** | **No** | **Macular Degeneration** |  |
| **Yes** | **No** | **Other:**  | **Yes** | **No** | **Retinal Disease** | **Use of alcohol:**  Yes No No Answer |
|  |  |  | **Yes** | **No** | **Eye Surgery:**  | **Use of tobacco:** Yes No No Answer |
|  |  |  | **Yes** | **No** | **Amblyopia/Lazy eye** | **Use of recreational drugs:** Yes No No Answer |
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| **WHO REFERED YOU TO US: 🞎 Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****🞎 Pediatrician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎 Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **🞎 Someone Else: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

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| **FEMALE ONLY: Are You Taking Birth Control Pills: Yes No Are You Pregnant: Yes No Are You taking Hormones: Yes No** |
| **Have you been HOSPITALIZED in the Past 2 years: YES NO If YES Explain:** |
| MEDICATIONS | ALLERGIES |
| **LIST MEDICATIONS you are currently taking:**  **NONE** | **List your allergies to any medications and/or general allergies:** **NONE** |
| **FAMILY HEALTH HISTORY List any family health conditions:** |

**PLEASE NOTE THE FOLLOWING READ AND UNDERSTAND:**

1. Due to differences between insurance’s whatever insurance/eye coverage we determine today, will be utilized in good faith.
2. No changes can be made in insurance usage and coverage after today.
3. **We can not combine insurance and promotions or discounts**
4. **Due to low reimbursement of eye & managed care plans we no longer can warranty any frames that are discounted.**
5. **ONLY glasses purchased at full retail will be warranted.**
6. **No refunds or exchanges however certain situations allow for office credits.**
7. **Progressive lenses warranty is only allowed 30 days from your examination and DOES NOT APLY TO GENERIC Progressive lenses. The Warranty is only available on PREMIUM Progressive Lenses.**
8. **If a patient can not adjust to a premium progressive lens then we will exchange it with a lined bifocal or single vision lenses at no additional charge and no refund is given for the initial expense.**
9. **If a patient can not adjust to a DISCOUNTED OR GENERIC progressive lens then you are responsible for paying for any changes with additional fees. No credit is given for the cost of generic lenses because there is no warranty on generic progressive lenses.**

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| **PLEASE CHECK METHOD OF PAYMENT: CASH CHECK**  **CREDIT/DEBIT CARD**  |

**1. Payment is expected at time when services are rendered**

**2. Full payment is required before orders are processed**

**3. Layaway plans are available**

**4. Any layaway orders left 30 days without any payments will be returned to stock & all monies paid are not refundable**

**5. Under no circumstances are refunds allowed however certain situations allow for office credits**

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| **AUTHORIZATION TO RELEASE INFORMATION AND UNDERSTANDING PATIENTS RESPONSIBILTY** |

1. I hereby authorize this office to release any information acquired in the course of this examination or treatment to your insurance carrier if requested by them

**2. I authorize any treatment deemed necessary by Dr. Rose**

**3. I also understand I am responsible for any fees not paid by Insurance**

**4. I have read understand and completed this form to the best of my knowledge**

**5. I understand no refunds or exchanges**

1. **I understand and read about frame warranties as explained above**

**I the undersigned certify that I (or my dependent) have insurance coverage indicated above and assign all benefits directly to Dr. Rose for services rendered when indicated. I also understand that I am financially responsible for any fees not paid, denied, or under paid by the insurance company. I am also responsible for all deductibles, coinsurance, and non-covered services. I have read and reviewed this entire page. I hereby authorize the doctor to release all information necessary to process this claim and any subsequent claims. I authorize the use of this signature for lifetime usage regarding all insurance submissions.**

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| **ASSIGNMENT AND RELEASE:** |
| **SIGNATURE of Patient or Legal Guardian:** |

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| **MAJOR MEDICAL INS:** | **INS HOLDER:**  | **ID#:** | **GROUP #:** | **EFFECTIVE DATE:** |
| **2ND MAJOR MEDICAL:** | **INS HOLDER:**  | **ID#:** | **GROUP #:** | **EFFECTIVE DATE:** |
| **VISION INSURANCE:** | **INS HOLDER:**  | **ID#:** | **GROUP #:** | **EFFECTIVE DATE:** |