

**See Clearly Vision / Cornea Consultants
Confidential Patient Registration**

Patient Name: _____ **Sex: M / F**
(Please Print) Last Name First Name Middle Initial (please circle)

Home Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Date of Birth: _____ **Social Security Number:** _____

How did you hear about us? _____

Employer: _____ **Occupation:** _____

Office Address: _____

City: _____ **State:** _____ **Zip Code:** _____

E-mail Address: _____

Pharmacy Name: _____ **Pharmacy Phone:** _____

Pharmacy Address: _____

Primary Insurance Information

Name of Insurance: _____ **ID#:** _____ **Group#:** _____

Subscriber Information:

Name: _____ **SS#:** _____ **Employer:** _____

Date of Birth: _____ **Relationship to Patient:** _____ **Work Phone:** _____

Secondary Insurance Information

Name of Insurance: _____ **ID#:** _____ **Group#:** _____

Subscriber Information:

Name: _____ **SS#:** _____ **Employer:** _____

Date of Birth: _____ **Relationship to Patient:** _____ **Work Phone:** _____

Vision Coverage Information (if applicable) **Name of Insurance:** _____ **ID#:** _____

Thank you for choosing See Clearly Vision. We appreciate the confidence you have placed in our practice and we take pride in providing you the highest quality of care.

We participate with many major medical and vision insurance plans. We will gladly bill all claims to the appropriate insurance plans on your behalf. You will be responsible for all co-pays, properly dated referrals, and deductibles or full payment at the time of service. If you have an appointment for a vision exam or a LASIK consultation and it is found that a medical condition is causing refractive error or a medical condition is detected, you will be responsible for all co-pays, referrals, and deductibles related to your medical insurance or for providing full payment at the time of service.

IF UNABLE TO KEEP YOUR APPOINTMENT, KINDLY GIVE 24 HOUR NOTICE. PLEASE NOTE THAT WITHOUT NOTICE, A \$25.00 CANCELLATION FEE WILL BE APPLIED TO YOUR ACCOUNT.

All balances beyond ninety days past due will be sent to our collection agency. You will be financially responsible for all collection and legal fees that our office incurs to collect the outstanding delinquent balance.

To be compliant with federal regulations, medical records will be kept for seven years. If requested, fees will be assessed for a copy of the records. Records will be properly disposed of after seven years.

All medical offices are obligated by law to provide access to our Notice of Privacy Practices. This notice outlines your patient rights and our methods for protecting your health information. Copies are available upon request.

“I request that payment of authorized Medicare benefits be made either to me or on my behalf to Cornea Consultants, PC for any services furnished me by physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its’ agents any information needed to determine these benefits or the benefits payable for related services.”

I understand and accept all terms and conditions of my examination and the financial policy.

Date: _____

Signature of Patient and/or Guardian(SEAL)

**See Clearly Vision / Cornea Consultants
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Patient Name: _____
Last Name First Name Middle Initial

Date of Birth: _____ **Primary Care Physician:** _____ **PCP #:** _____

Emergency Contact: _____ **Phone Number:** _____

Please answer the following EYE HISTORY questions about YOURSELF:

Do you have any of the following eye conditions?	Yes	No	If yes, please explain
CATARACTS			
GLAUCOMA			
MACULAR DEGENERATION			
“LAZY EYE” or Strabismus or “Eye Turn”			
RETINAL DETACHMENT			
CORNEAL DISEASE			
DRY EYE			
KERATOCONUS			

Please answer the following MEDICAL HISTORY questions about YOURSELF:

Do you have any of the following medical conditions?	Yes	No	If yes, please explain
NEUROLOGIC CONDITION			
STROKE			
HEADACHES			
ASTHMA OR BREATHING CONDITIONS			
EAR/NOSE/THROAT CONDITIONS			
ENVIRONMENTAL/SEASONAL ALLERGIES			
HEART DISEASE OR HEART CONDITIONS			
HIGH CHOLESTEROL			
BLEEDING DISORDERS			
HIGH BLOOD PRESSURE			
DIABETES			
KIDNEY CONDITIONS			
LIVER CONDITIONS OR HEPATITIS			
URINARY CONDITIONS			
AUTOIMMUNE CONDITIONS			
THYROID CONDITIONS			
HIV			
CANCER			
Are you currently PREGNANT/BREASTFEEDING?			
ANXIETY/DEPRESSION			
PSYCHIATRIC CONDITION			
<i>Have you ever been hospitalized or had surgery?</i>			
<i>Do you smoke?</i>			pack(s) a day
<i>Do you drink?</i>			drink(s) per wk
<i>Are you interested in laser eye surgery or contact lenses?</i>			
<i>Are you interested in BOTOX or Juvéderm?</i>			

Have you ever had eye surgery? (Please Circle) YES NO If yes, please explain: _____

Do you have any family history of eye conditions (i.e. cataracts, glaucoma, etc)? (Please circle) YES NO
If yes, please explain _____

Do you take any prescriptions, supplements, or over the counter medications? (Please circle) YES NO
If yes, please explain _____

Are you allergic to any medications? (Please circle) YES NO If yes, please explain _____

Comments or other medical history not listed above: _____

Patient Signature: _____ **Date:** _____

Reviewed: Doctor Signature: _____ **Date:** _____