See Clearly Vision / Cornea Consultants
Confidential Patient Registration

Patient Name: ____ **Gender: 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 (mm/dd/yyyy): _____________________ **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 in a manner which protects patient confidentiality.

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)

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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			
Have you ever been hospitalized or had surgery?			
Do you smoke?			pack(s) a day
Do you drink?			drink(s) per wk
Are you interested in laser eye surgery or contact lenses?			
Are you interested in BOTOX or Juvéderm?			

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:**_______________________