

**See Clearly Vision
Cornea Consultants**

Patient Name: _____
(Please Print) Last Name First Name Middle Initial

Home Address: _____

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

Home Phone: _____ **Work Phone:** _____ **Sex:** M / F

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

How did you hear about us? _____

Employer: _____ **Occupation:** _____

Office Address: _____

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

E-mail Address: _____

Primary Insurance Information

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

Subscriber Information:

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

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

Vision Coverage Information **Name of Insurance:** _____ **ID#:** _____

Secondary Insurance Information

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

Subscriber Information:

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

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

We participate with most major medical and vision insurance plans. We will 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 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.

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.

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.

Signature of Patient and/or Guardian (SEAL) **Date:** _____

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

Patient Name: _____
Last Name First Name Middle Initial
Date of Birth: _____ **Name of Primary Care Physician:** _____

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”			
RETINAL DETACHMENT			
CORNEAL DISEASE			

Have you had any eye surgery? If yes, please explain _____

Please list any eye conditions that run in your family. _____

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			
HIV			
CANCER			
PREGNANCY/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>If eye condition is due to an injury, is injury work related or a result of a motor vehicle accident?</i>			

Please list your current prescriptions, over the counter medications and eye drops _____

Are you allergic to any medications? If yes, please list. _____

Comments or other medical history not listed above: _____

Patient Signature: _____ **Date:** _____

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