VILLAGE EYECARE

PATIENT REGISTRATION FORM

PATIENT NAME ______________________ TODAY'S DATE ____________ (M/D/Y)

ADDRESS ______________________

CELL PHONE (   ) ______________ DAY TIME PHONE (   ) ______________

GENDER ☐ M ☐ F SSN ______________ BIRTHDATE ____________ (M/D/Y)

E-MAIL ADDRESS ______________ TEXT & EMAIL NOTIFICATIONS ☐ Yes ☐ No

EMPLOYMENT STATUS

☐ Full Time ☐ Part Time ☐ Retired ☐ Self-Employed ☐ Unemployed

MARITAL STATUS

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Domestic Partner

OCCUPATION ______________ STUDENT ☐ Yes ☐ No ______________

HOW DID YOUR HEAR ABOUT US?

☐ Insurance ☐ Google ☐ Walk-in ☐ Yelp! ☐ Mailer ☐ Facebook ☐ Other ______________

☐ Referral - Who? ______________

INSURANCE INFORMATION

RELATIONSHIP TO INSURED ☐ Self ☐ Spouse ☐ Dependent ☐ Child ☐ Other

Responsible Party/Guarantor (if minor) ______________

VISION INSURANCE ______________	MEDICAL INSURANCE ______________
ID or SSN ______________	ID or SSN ______________
GROUP NUMBER ______________	GROUP NUMBER ______________
PRIMARY NAME ______________	PRIMARY NAME ______________
PRIMARY BIRTHDATE ______________ (M/D/Y)	PRIMARY BIRTHDATE ______________ (M/D/Y)

EMERGENCY CONTACT

NAME ______________ PHONE ______________

FINANCIAL POLICY

Thank you for choosing Village Eyecare for your eye care needs. We are happy to serve you, and look forward to a long relationship with you, our valued patient. In an effort to serve you efficiently, we have instituted the following financial policy. This policy outlines the understanding between you, the patient, and our office. Our office will, as a courtesy, file insurance claims based upon information you have provided us if we are a participating provider in your insurance plan. It is your responsibility to provide us with complete and accurate information. Furthermore, if your insurance company requests more information from you, you must provide that information promptly. By signing below, you understand that you will be responsible for payment of any services not paid by your insurance company which includes co-payments, deductibles, coinsurance, and non-covered items, and denied services not covered by contract between our office and your insurer. If your claim is denied, it becomes your responsibility to pay the retail cost of those services and/or product. We will assist you in any way possible to be sure that the claim is handled properly: we will file our insurance claim for you and send a remainder statement when there is a balance to be paid by you. In some cases where deemed necessary, we reserve the right to refer uncollected balances to an outside collection agency. By keeping lines of communication open and providing accurate information, you can be sure that your claims will be handled promptly and efficiently. I understand that all accounts are full responsibility of the patient and/or the patient's responsible party/guarantor. In case of default payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection to this account or future outstanding accounts.

____

PATIENT SIGNATURE Responsible Party/Guarantor Signature (if minor) DATE

VILLAGE EYECARE

PATIENT OCULAR HISTORY FORM

(Please answer the following questions to the best of your ability. They will help us provide you with a more thorough eye examination.)

PATIENT NAME ______________________ **DATE** __________

LAST EYE EXAM ______________________ **LOCATION** __________

OCULAR HISTORY

Have you experienced any of the following? (please check all that apply)

- ☐ Blurred Distance Vision
- ☐ Blurred Near Vision
- ☐ Eyestrain/Eye Fatigue
- ☐ Double Vision
- ☐ Headache
- ☐ Itching
- ☐ Watering
- ☐ Redness
- ☐ Burning
- ☐ Dry Feeling/Sandy/Gritty
- ☐ Night Vision Difficulty
- ☐ Light Sensitivity

Have you noticed floaters, shadows or flashes of light in your vision? ☐ Yes ☐ No

Do you use any over-the-counter eye drops? ☐ Yes ☐ No

What is your primary visual concern? ______________________

EYEWEAR HISTORY

Do you currently wear eyeglasses? ______________________ Last Updated? __________

☐ All The Time ☐ Distance ☐ Reading/Computer ☐ Work Safety ☐ As Needed

How many days a week do you wear your glasses? ______________________ Hours per day? __________

How many hours per day are you on a computer?

Do you wear prescription sunglasses? ☐ Yes ☐ No

Do you currently use contact lenses? ☐ Yes ☐ No Interested in trying them? ☐ Yes ☐ No

Are you interested in Laser Vision Correction? ☐ Yes ☐ No More information? ☐ Yes ☐ No

CONTACT LENS HISTORY

How many days a week are you wearing contact lenses? ______________________

How many hours a day do you wear your contact lenses? ______________________

How often do you dispose of your contact lenses? ______________________

Are you experiencing any problems/discomfort with your current contact lenses? ☐ Yes ☐ No

(explain) ______________________

What brand and type of contact lenses do you use? ______________________

Right Eye Power ______________________ Left Eye Power ______________________

Which solution system are you currently using?

- ☐ Opti-Free
- ☐ ReNu
- ☐ Bio true
- ☐ Clear Care
- ☐ OcuSoft
- ☐ Sauflon
- ☐ Boston
- ☐ Other __________

VILLAGE EYECARE

PATIENT MEDICAL HISTORY FORM

Please list all medications you are taking, both prescribed and over the counter. (include vitamins and supplements)

____

____

Do you have any allergies? ☐ Yes ☐ No ____________________

Do you have any medication allergies? ☐ Yes ☐ No ____________________

Are you pregnant or nursing? ☐ Yes ☐ No ____________________

Have you ever had eye injuries? ☐ Yes ☐ No ____________________

Have you or any of your immediate family had or have any of the following conditions? (please check all that apply)

Condition	Yourself	Your Family	Condition	Yourself	Your Family
Amblyopia	☐ Yes ☐ No	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	☐ Yes ☐ No
Cataract	☐ Yes ☐ No	☐ Yes ☐ No	Hypertension	☐ Yes ☐ No	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	☐ Yes ☐ No
Macular Degeneration	☐ Yes ☐ No	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	☐ Yes ☐ No
Retinal Detachment	☐ Yes ☐ No	☐ Yes ☐ No	Thyroid Disorder	☐ Yes ☐ No	☐ Yes ☐ No
Eye Surgery	☐ Yes ☐ No	☐ Yes ☐ No	Cancer	☐ Yes ☐ No	☐ Yes ☐ No
Please Specify: ____________			Please Specify: ____________		
Headaches	☐ Yes ☐ No	☐ Yes ☐ No	Sinusitis	☐ Yes ☐ No	☐ Yes ☐ No
Migraines	☐ Yes ☐ No	☐ Yes ☐ No	Asthma	☐ Yes ☐ No	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	☐ Yes ☐ No	HIV/AIDS	☐ Yes ☐ No	☐ Yes ☐ No
Leukemia	☐ Yes ☐ No	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	☐ Yes ☐ No
Other Blood Disorders	☐ Yes ☐ No	☐ Yes ☐ No	Other	☐ Yes ☐ No	☐ Yes ☐ No
Please Specify: ____________			Please Specify: ____________		
Acne Rosacea	☐ Yes ☐ No	☐ Yes ☐ No	Neurological Disorders	☐ Yes ☐ No	☐ Yes ☐ No
Other Skin Disorders	☐ Yes ☐ No	☐ Yes ☐ No	Psychiatric Disorders	☐ Yes ☐ No	☐ Yes ☐ No
Please Specify: ____________			Please Specify: ____________		

Do you use cigarettes/tobacco? ☐ Yes ☐ No

If yes, how many packs per day? ____________________

Do you drink alcohol? ☐ Yes ☐ No How often? ____________________

Do you have any other health concerns? ☐ Yes ☐ No

Please Specify: ____________________

____

VILLAGE EYECARE

NOTICE OF PRIVACY PRACTICE

____

PATIENT NAME

____

DATE OF BIRTH

I have read and reviewed this practice's Notice of Privacy Practice. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, and the practice's legal duties with respect to my protected health information.

I understand that this practice reserves the right to change the terms of it's Notice of Privacy Practice and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practice on request.

____

SIGNATURE

____

DATE

____

RELATIONSHIP TO PATIENT
(if signed by a personal representative of patient)