Welcome to Lovato Eyecare

Patient Registration Form

Patient Name_____ Today's Date_____

Male_____ Female_____ Referring Doctor's Name_____

DOB_____/_____/_____ Age _____ Social Security #_____

Race_____ Ethnicity_____ Preferred language_____

Address_____City_____State_____Zip_____

Home Phone _____ Work Phone_____

Cell Phone _____ Email address_____

Emergency Contact/Relation_____/_____Phone_____

Do you have **VISION** insurance?_____ Ins co name/phone #:_____

Policyholder Name_____ Employer_____

Relation to patient_____ Policyholder DOB _____/____/____ SS#_____

Do you have **MEDICAL** insurance?_____ Ins co name/phone #:_____

Policyholder Name_____ Employer_____

Relation to patient_____ Policyholder DOB____/____/____ SS#_____

Do you have **SECONDARY** insurance?_____ Ins co name/phone #:_____

Policyholder Name_____ Employer_____

Relation to patient_____ Policyholder DOB____/____/____ SS#_____

Date of last eye exam? _____ Name of last eye doctor_____

Purpose for today's visit (circle one) annual exam glasses contacts medical other

Who can we thank for referring you today?_____

Social History

Do you use tobacco? Yes___ No___ Amount_____ Marital Status____ # of Children_____

Do you use alcohol? Yes___ No___ Amount_____ Full-time Student Yes___No___

Employer_____ Occupation_____

Hobbies/Sports/Special visual demands_____

Past Medical History

List all current medications_____

_____

_____

List all medications you are allergic to_____

List all surgical/ocular procedures_____

Self & Family Medical History

	Self		Mom, Dad, Siblings, Grandparents		
Amblyopia (lazy eye)	yes	no	yes	no	relation_____
Birth defects	yes	no	yes	no	relation_____
Cataracts	yes	no	yes	no	relation_____
Cancer	yes	no	yes	no	relation_____
Glaucoma	yes	no	yes	no	relation_____
Diabetes type I or II	yes	no	yes	no	relation_____
Heart Disease	yes	no	yes	no	relation_____
High Blood Pressure	yes	no	yes	no	relation_____
Seizure disorder	yes	no	yes	no	relation_____
Macular disease	yes	no	yes	no	relation_____

Review Systems

Do you currently have any of the following?	**Circle yes or no and if yes, please explain:**
Blurred vision, double vision, loss of vision	yes no explain_____
Chronic Fever, Unexpected Weight Loss/Gain, Fatigue	yes no explain_____
Ear/nose/throat problems (hearing loss, sinus issues)	yes no explain_____
Cardiovascular problems (irreg heart beat, chest pain)	yes no explain_____
Respiratory problems (asthma, shortness of breath, TB)	yes no explain_____
Gastrointestinal problems (heart burn, liver disease)	yes no explain_____
Genitourinary problems (kidney disease, kidney stones)	yes no explain_____
Skin/breast problems (skin rash, breast cancer)	yes no explain_____
Musculoskeletal problems (arthritis, neck/back pain)	yes no explain_____
Neurologic problems (headaches, dizziness, stroke)	yes no explain_____
Hematologic/ lymphatic problems (anemia, Leukemia)	yes no explain_____
Allergic/Immune problems (allergies, immune disorder)	yes no explain_____

Any condition not listed above, please explain:_____

_____

Statement of Financial Responsibility

It is Lovato Eyecare's financial policy to bill your insurance company as a courtesy to you although you do remain responsible for the entire bill. Once the insurance company is billed, we will set aside the estimated portion due from the insurance company for 60 days. If you should receive any payments from your insurance carrier for services still due to us, please remit those payments to us immediately. If you have no insurance coverage, payment in full will be expected at time of service. The billing department must establish any other type of payment arrangements.

For Medicaid, Medicare, Workers Compensation and Managed Care claims, we will bill all services. No payment other than applicable co-payments or co-insurance will be expected from the patient at the time of service unless the services are denied for reasons of expired eligibility or acceptance. Please note that proof of Medicaid eligibility is required at the time of service. For our Medicare patients, Lovato Eyecare is a participating provider and as such, we accept Medicare assignment. You are responsible only for the co-insurance, deductible and any non-covered services.

Assignment of Insurance Benefits

I hereby authorize direct payment to the Lovato Eyecare of any insurance benefits otherwise payable to me or on my behalf for services performed by any Lovato Eyecare physician. I understand that my insurance is billed as a courtesy and I am financially responsible for all charges not covered by this assignment of benefits. **If a medical problem exists at the time of any exam, your medical insurance will be billed, not your vision plan. Deductible, copay, and co-insurance are your responsibility.**

Referrals

I understand that if my insurance required a referral for a specialist visit, it is **my** responsibility to obtain and provide this documentation. If I fail to provide a referral, I understand my visit will be rescheduled.

Authorization for Release of Information

I authorize Lovato Eyecare to release medical information concerning my care and treatments as may be required by the third party payers for the purpose of processing claim payment.

Collection Agency Accounts

In the event that this account is placed with a collection agency, I agree to be responsible for the collection fees, reasonable attorney's fees and court costs.

No Show Policy

I understand that if I do not keep two (2) consecutive appointments without calling to cancel or reschedule, I will be terminated from the practice. Upon request, my medical records will be transferred to another provider.

My signature acknowledges the understanding and acceptance of the above policy statements.

X_____ _____

Patient or Guardian Signature Date

HIPAA

I acknowledge that I have been given an opportunity to review and/or have received a copy of the notice of privacy practices as required by HIPAA.

X_____ _____

Patient or Guardian Signature Date

_____ _____

Witness Date