EYECARE REGISTRATION FORM

PATIENT INFORMATION:

Date: ______________________________

Patient's Name: ____

Last Name First Name Middle Initial

Street Address: ____

City: ______________________________________ State:____________ Zip: ____________

Home Phone:_________________________________ Cell Phone: _________________________

Employer/School: ____________________________ Employer Phone: ____________________

Email address: ______________________________ Social Security Number: _____________

Sex: Female Male Age: ________ Birth Date: ________________________

Best time & place to reach you: ____

Emergency Contact: ____

Marital Status: Married Widowed Divorced Separated Single Minor

Spouse's/Guardian's Name: ____

Spouse's/Guardian's Employer:____

Spouse's/Guardian's Birth Date: ________________ Spouse's/Guardian's SS#: ____________

EYE HEALTH HISTORY

Date of Last Eye Exam: __________ Doctor or Location for Last Eye Exam: ________________

Medical Physician's Name: ____

Medical Physician's Address: ____

Medical Physician's Phone Number: ____

Do you wear **Glasses**? Yes No __ Full-Time __ Part-time __ Reading __ Driving __ TV

How old is your current pair of glasses? ______________

Do you wear C**ontact Lenses**? Yes No Brand _____________________ Hours/Day Worn __

Do you sleep in your contact lenses? Yes No How old is your current pair of CLs? ____

Describe any problems you have with your contacts: _______________________________

Place a mark on "Yes" or "No" to indicate if <u>you</u> have had any of the following:

Bloodshot Eyes	__yes	__no	Glaucoma	__yes	__no
Blurry-Distance (with current Rx)	__yes	__no	Headaches	__yes	__no
Blurry-Near (with current Rx)	__yes	__no	Itching Eyes	__yes	__no
Burning Eyes	__yes	__no	Light Sensitive	__yes	__no
Cataracts	__yes	__no	Loss of Vision	__yes	__no
Crossed Eyes	__yes	__no	Migraine Headaches	__yes	__no
Discharge from Eyes	__yes	__no	Poor Color Vision	__yes	__no
Dizzy Spells	__yes	__no	Poor Night Vision	__yes	__no
Double Vision	__yes	__no	Red Eyes	__yes	__no
Dry Eyes	__yes	__no	Seeing Halos	__yes	__no
Eye Infection	__yes	__no	Seeing Flashes	__yes	__no
Eye Injury	__yes	__no	Temporary Loss of Vision	__yes	__no
Eye Strain	__yes	__no	Twitching Eyelid	__yes	__no
Fainting Spells, Blackouts	__yes	__no	Vision Poor	__yes	__no
Floaters or Spots	__yes	__no	Watering Eyes	__yes	__no

INSURANCE AUTHORIZATION:

Who is the subscriber for this insurance? ________________________________

Birth Date of subscriber: ________________________________

Subscriber's Social Security Number: ________________________________

Assignment and Release: I certify that I, and/or my dependent(s) have insurance coverage with ____ and assign directly to **Dr. Lewis F. Jones, III O.D.**
(Name of Insurance Company)
or Dr. Stephanie R. Goggin, O.D., all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above named insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed.

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Signature of Patient, Parent, Guardian or Personal Representative

____________________ ________________________________

Date Relationship to Patient

FOR MEDICARE/MEDIGAP INSURED ONLY:

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to **Lewis F. Jones III, O.D/Stephanie Goggin, O.D./Metro Eye Care** for any services furnished to me by that provider.

To the extent permitted by law, I authorized any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

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Signature of Patient, Beneficiary, Guardian or Personal Representative

____________________ ________________________________

Date Relationship to Patient