



**PEDIATRIC OPHTHALMOLOGY
& ADULT STRABISMUS**

David Stager, Jr., MD, FACS, FAAP

3801 W. 15th St.
Suite A-110
Plano, TX 75075

Patient Registration Form

Patient Information (for both adult and pediatric patients)	
Patient Name _____	<input type="checkbox"/> Male <input type="checkbox"/> Female
Street: _____	City: _____ State: _____ Zip: _____
Home Phone: _____	Cell Phone: _____
Date of Birth: _____	Social Security # _____
Email Address _____	
Referring Physician _____	Telephone # _____
Primary Physician _____	Telephone # _____
Patient's or Parent/Guardian's Employer _____	
Address _____	
Work Phone # _____	
Emergency Contact Name: _____	Phone # _____

Pediatric Patient Family Information (not required for adult patients)	
Family status: Patient is living with: <input type="checkbox"/> Parents <input type="checkbox"/> Relative <input type="checkbox"/> Guardian <input type="checkbox"/> Foster parents.	
Patients parents are: <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced	
Full Name of Father (or Guardian): _____	Full Name of Mother (or Guardian): _____
Social Security Number: _____	Social Security Number: _____
Date of Birth: _____	Date of Birth: _____
Home Address: _____	Home Address: _____
_____	_____
_____	_____
Telephone #: _____	Telephone #: _____
E-mail Address: _____	E-mail Address: _____

Reason for visit



Patient History (1 of 2)

Patient's History of Eye Problems							
Family History: Is the patient natural _____ adopted _____							
Yes No							
<input type="checkbox"/>	<input type="checkbox"/>	Glasses: How old is the current pair? _____					
<input type="checkbox"/>	<input type="checkbox"/>	Contacts: How old is the current pair? _____					
<input type="checkbox"/>	<input type="checkbox"/>	Prisms: How Long? _____					
<u>Yes</u>	<u>No</u>	<u>Past Ocular History:</u>	<u>Age</u>	<u>Yes</u>	<u>No</u>	<u>Past Ocular History</u>	<u>Age</u>
<input type="checkbox"/>	<input type="checkbox"/>	Eye exam by specialist	_____	<input type="checkbox"/>	<input type="checkbox"/>	Eye Injury	_____
<input type="checkbox"/>	<input type="checkbox"/>	Patching	_____	<input type="checkbox"/>	<input type="checkbox"/>	Stye	_____
<input type="checkbox"/>	<input type="checkbox"/>	Eye exercises	_____	<input type="checkbox"/>	<input type="checkbox"/>	Recurring "pinkeye"	_____
<input type="checkbox"/>	<input type="checkbox"/>	Eye muscle surgery	_____	<input type="checkbox"/>	<input type="checkbox"/>	Cataract	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other eye surgery	_____	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	_____
<input type="checkbox"/>	<input type="checkbox"/>	Diabetic eye disease	_____				
Diagnosed eye diseases not mentioned above							

Eye Conditions In Other Family Members												
<u>Yes</u> <u>No</u>		<u>Which relative? (check one)</u>										
<input type="checkbox"/>	<input type="checkbox"/>	Glasses before age 6	<input type="checkbox"/>	Father	<input type="checkbox"/>	Mother	<input type="checkbox"/>	Sister	<input type="checkbox"/>	Brother	<input type="checkbox"/>	Other
<input type="checkbox"/>	<input type="checkbox"/>	Amblyopia ("lazy eye")	<input type="checkbox"/>	Father	<input type="checkbox"/>	Mother	<input type="checkbox"/>	Sister	<input type="checkbox"/>	Brother	<input type="checkbox"/>	Other
<input type="checkbox"/>	<input type="checkbox"/>	Patching treatment	<input type="checkbox"/>	Father	<input type="checkbox"/>	Mother	<input type="checkbox"/>	Sister	<input type="checkbox"/>	Brother	<input type="checkbox"/>	Other
<input type="checkbox"/>	<input type="checkbox"/>	Strabismus (crossed or wandering eye)	<input type="checkbox"/>	Father	<input type="checkbox"/>	Mother	<input type="checkbox"/>	Sister	<input type="checkbox"/>	Brother	<input type="checkbox"/>	Other
<input type="checkbox"/>	<input type="checkbox"/>	Eye muscle surgery	<input type="checkbox"/>	Father	<input type="checkbox"/>	Mother	<input type="checkbox"/>	Sister	<input type="checkbox"/>	Brother	<input type="checkbox"/>	Other
<input type="checkbox"/>	<input type="checkbox"/>	Cataracts	<input type="checkbox"/>	Father	<input type="checkbox"/>	Mother	<input type="checkbox"/>	Sister	<input type="checkbox"/>	Brother	<input type="checkbox"/>	Other
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	Father	<input type="checkbox"/>	Mother	<input type="checkbox"/>	Sister	<input type="checkbox"/>	Brother	<input type="checkbox"/>	Other
Other Serious eye disease (describe)												

Brothers and Sisters (Not required for Adult patients)												
<u>Full Name</u>		<u>Age</u>		<u>Is he/she a patient of Dr. Stager's?</u>								
_____		_____		<input type="checkbox"/> Yes <input type="checkbox"/> No								
_____		_____		<input type="checkbox"/> Yes <input type="checkbox"/> No								
_____		_____		<input type="checkbox"/> Yes <input type="checkbox"/> No								
_____		_____		<input type="checkbox"/> Yes <input type="checkbox"/> No								
_____		_____		<input type="checkbox"/> Yes <input type="checkbox"/> No								



**PEDIATRIC OPHTHALMOLOGY
& ADULT STRABISMUS**

3801 W. 15th St., Suite A-110
Plano, TX 75075

David Stager, Jr., MD, FACS, FAAP

**Patient History
(2 of 2)**

Patient's Medical History					
Yes	No	Condition	Yes	No	Condition
<input type="checkbox"/>	<input type="checkbox"/>	Frequent ear infections	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Sinus Disease	<input type="checkbox"/>	<input type="checkbox"/>	Anemia
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Neurological disease
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Seizures or stroke
<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problem	<input type="checkbox"/>	<input type="checkbox"/>	Other illness not mentioned (describe below)
<input type="checkbox"/>	<input type="checkbox"/>	Previous surgery or hospitalization			

Patient's Medication	
Eye drop and frequency: _____	Why is this medication being used? _____
Medication and dosage: _____	Why is this medication being used? _____
List any known allergies to medication: _____	

Patient's Birth History (not required for adult patients)		
Birth Weight	_____ lb _____ oz.	
Yes	No	Condition
<input type="checkbox"/>	<input type="checkbox"/>	Problems in pregnancy. Describe: _____
<input type="checkbox"/>	<input type="checkbox"/>	Problems in delivery. Describe: _____
<input type="checkbox"/>	<input type="checkbox"/>	Forceps delivery
<input type="checkbox"/>	<input type="checkbox"/>	Cesarean section
<input type="checkbox"/>	<input type="checkbox"/>	Delivered early
<input type="checkbox"/>	<input type="checkbox"/>	Delivered late
<input type="checkbox"/>	<input type="checkbox"/>	Baby kept in hospital due to illness. Why and how long? _____
<input type="checkbox"/>	<input type="checkbox"/>	Delay in sitting, walking, talking or development. Describe: _____
<input type="checkbox"/>	<input type="checkbox"/>	Any outstanding school difficulties. Describe: _____



**PEDIATRIC OPHTHALMOLOGY
& ADULT STRABISMUS**

3801 W. 15th St., Suite A-110
Plano, TX 75075

David Stager, Jr., MD, FACS, FAAP

Financial Responsibility

As a specialty practice we strive to keep our fees competitive and as low as we can. To accomplish that we feel it is important that we have a good understanding with our patients regarding financial responsibility. We hope this summary is helpful toward this goal and we encourage you to ask our staff any questions you may have.

- o We must have a current copy of your medical insurance card. If this is not available, payment in full for the office visit will be expected at the time of service. We do not file claims to Vision Insurance plans.
- o Any deductibles, coinsurance and co-payment amounts are due at the time of service.
- o If we are contracted with your insurance plan we will submit the remainder to your insurance carrier.
- o If your insurance plan mistakenly sends payment directly to you, please send us a personal check as well as the paperwork from the insurance carrier.
- o You are responsible for any services not covered by your insurance policy.
- o Medical insurance plans will sometimes refuse to pay for a claim for any of the following reasons:
 - Pre-existing conditions
 - The individual or family deductible has not been met
 - The policy was not in effect at the time of service
 - There is another insurance policy that is considered primary
 - The type of service is not covered on your policy.

Although we make every effort to verify your insurance benefits prior to the appointment date or at the time of service, the payment we collect may not reflect the full patient responsibility. Please be aware that financial responsibility for medical services is between you and your health plan/insurance carrier. While we are happy to submit your insurance claim on your behalf, we are not responsible for any limitations or exclusions in your plan's coverage. If your insurance carrier denies your claim you will be responsible for payment in full.

Our mission is to provide you with excellent quality care at cost-effective, competitive pricing. We are constantly adapting to the changing policies of health insurance carriers and the federal government. We value you as a patient and welcome you to our practice.

I have read and understand my obligations. I acknowledge that I am fully responsible for payment of services if not covered by my insurance carrier or the practice is not contracted with my health plan. Any questions I may have had regarding this policy have been answered by the staff of Dr. Stager Jr./ Dr. Stager Sr.

Patient or Guardian Signature

Date

Printed Name



PEDIATRIC OPHTHALMOLOGY
& ADULT STRABISMUS

3801 W. 15th St., Suite A-110
Plano, TX 75075

David Stager, Jr., MD, FACS, FAAP

Office Policy

In order to improve our efficiency and help ensure a pleasant office visit, please read the following:

- o Please bring any current glasses or contact lenses with you to every visit.
- o Please help us stay on schedule by arriving on time for your scheduled appointment. If you arrive more than 20 minutes late your appointment may need to be rescheduled.
- o As a courtesy to staff and others in the waiting room, please turn off your cellular/mobile telephone.
- o When scheduling your appointment, please provide us with your insurance policy/ID number and group number as well as the telephone numbers listed on the back of the insurance card. We will make every effort to verify your insurance coverage and benefits before the day of your visit.
- o We contract and are "in network" with many PPO, POS, EPO and HMO insurance plans. If your plan requires a referral number, please provide this to us when scheduling your appointment. The referral is usually obtained from your Primary Care Physician (PCP).
- o If we are contracted with your insurance plan, we will file your insurance claim for you. As stated in our Patient Financial Responsibility Statement, you are required to pay your co-pay and/or coinsurance and/or deductible amount (if not met for the year) at the time of your visit.
- o If a parent or guardian cannot accompany the minor patient to the exam, a **written** authorization from the parent/guardian must be presented by the person bringing the patient to the appointment. We are unable to examine the patient without this authorization.
- o If the minor patient's parents are divorced, payment is the responsibility of the parent bringing the child to the office for treatment, regardless of the terms of the divorce decree.
- o In compliance with federal privacy policies, no information regarding a patient(s) will be released without written authorization from the patient, parent, or guardian. Please see the link for the Medical Records Release Form.



**PEDIATRIC OPHTHALMOLOGY
& ADULT STRABISMUS**

3801 W. 15th St., Suite A-110
Plano, TX 75075

David Stager, Jr., MD, FACS, FAAP

Insurance/Payment

Insurance Information	
PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Name: _____	Insurance Name: _____
Policy Number: _____	Policy Number: _____
Group Number: _____	Group Number: _____
Subscriber Name: _____	Subscriber Name: _____
Subscriber Address: _____	Subscriber Address: _____
Subscriber SS# _____ Birth Date _____	Subscriber SS# _____ Birth Date _____
Relationship to Patient: _____	Relationship to Patient: _____

Insurance Authorization and Assignment	
<p>I hereby authorize my insurance carrier(s), including Medicare to issue payment directly to David Stager Jr, M.D., F.A.C.S., F.A.A.P./ David R. Stager Sr, M.D., F.A.C.S. for medical services rendered to myself and/or my dependent regardless of my Insurance benefits. I understand that I am responsible for any amount not covered by insurance.</p> <p>I hereby authorize David Stager Jr, M.D., F.A.C.S., F.A.A.P./David R. Stager Sr, M.D., F.A.C.S., to (1) release any information to insurance carrier regarding my illness and treatment, (2) to process claims generated in the course of examination, or treatment, and (3) to allow a photocopy of my signature to be used to process insurance claims.</p>	
_____ Signature of Patient / Legal Guardian	_____ Date

Authorization	
<p>I hereby give my consent to the physician and other clinical personnel of David Stager Jr, M.D., F.A.C.S., F.A.A.P./ David R. Stager Sr, M.D., F.A.C.S., for my evaluation and treatment on an ongoing basis.</p> <p>I understand that I have the right to revoke this consent in writing, at any time, except when the physicians or other clinical personnel have already taken action on my consent.</p>	
_____ Signature of Patient / Legal Guardian	_____ Date

**Acknowledgement of Review of
Notice of Privacy Practices**

I have reviewed the Notice of Privacy Practices for David Stager Jr., M.D., F.A.C.S.,
which explains how my medical information will be
used and disclosed. I understand that I am entitled to receive a copy of this document.

Patient Name

Relationship to Patient

Date

Signature of Patient or Personal Representative

David Stager Jr, MD. FACS

Policy Regarding Refraction and Routine Eye Care Exams

Refraction is the process of determining the eye's need for corrective lenses, or the eye's refractive error. Dilation of the pupil may not always be required to perform this procedure and does not always mean an eyeglass prescription will be required.

Refraction is part of a complete eye exam, but is generally not considered a covered expense under Medicare and most managed care plans, such as HMO's and PPO's. Therefore, the patient is typically responsible for these charges.

The fee for the refraction is \$50.00 in addition to any co-payment applicable to your insurance plan. In the absence of a medical condition other than a refractive error, most routine eye exams are also considered a non-covered service under most medical insurance plans. The performance of this service is determined solely by the doctor and may or may not be a part of services provide to you today.

I have read the above and agree to pay David Stager, Jr. MD.,
for all services that are not covered under my insurance plan in addition to any co-pays and deductibles.

Patient name: _____ Date: _____

Signature of Responsible Party: _____

VALID FOR 1 YEAR