EAST BAY Eye Specialists

491 30th Street, Suite 201
Oakland, CA 94609
(510)836-2122 Fax (510)836-3773

PATIENT REGISTRATION FORM

Patient Name:

Last: _____

First:_____ **Middle Initial:** _____

Date of Birth : _____/_____/_____ **Sex:** ____**M** ____**F**

Social Security #: _____/_____/_____

State ID/Driver's License: _____ _____

Marital Status : _____

Patient Address:

Emergency Contact Info :

Name: _____

Relation: _____

Phone#: _____

Primary Phone #: ( ) _____ - _____
(Home / work / mobile / other) Please circle

Secondary Phone #: ( ) _____ - _____
(Home / work / mobile / other) Please circle

Name of Parent/Guardian:_____

(If patient is a child/minor under 18 years of age)

PREFERRED CONTACT METHOD:

❒ Home ❒ Work ❒ Mobile ❒ Mail

OCCUPATION: _____ **EMPLOYER:** _____

RACE :	❒ Asian ❒ Hispanic	❒ African American ❒ Pacific Islander	❒ American Indian ❒ Other:_____	❒ Caucasian ❒ Decline

ETHNICITY: ❒ Hispanic ❒Non-Hispanic ❒ Decline

LANGUAGE: ❒ Decline	❒ English ❒ Other:_____	❒ Cantonese ❒ Mandarin ❒ Korean	❒ Tagalog ❒ Spanish ❒ Vietnamese

Primary Insurance:_____

ID#:_____

Primary Care Physician: _____

Phone #: _____

Secondary Insurance: _____

ID #:_____

Referring Physician: _____

Phone #:_____

Other Insurance / Vision Plan: _____

Pharmacy: _____

Address: _____

How did you hear about us:

❒ Another Patient ❒ Website ❒ other: _____	❒ Primary Care Physician ❒ Relative ❒ Internet	❒ Optometrist ❒ My Insurance ❒ Hospital	❒ Physician: _____ ❒ NP / PA ❒ Yellow Pages / YP.com

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PATIENT MEDICAL HISTORY

Are you currently experiencing any of the following symptoms in your EYES? (Please check any that apply)					
❒ Eye pain	❒ Burning ❒ Itching ❒ Scratching sensation	❒ Redness	❒ Tearing	❒ Discharge	❒ Dark spots or Dark veils
❒ Blurred or fuzzy vision	❒ Double vision	❒ Problems with glasses	❒ Flashing lights	❒ Cobwebs or floaters	❒ Headache
❒ Other:					

Family History: ❒ Glaucoma ❒ Macular Degeneration ❒ Retinal Detachments ❒ Diabetes ❒ Cancer

Do you have now or have you ever had? (Please check any that apply)				
❒ Diabetes	❒ Heart Disease	❒ High Blood Pressure	❒ High Cholesterol	❒ HIV
❒ Asthma	❒ Cancer or Tumors	❒ Stroke	❒ Thyroid Disease	❒ Pregnant or Nursing
❒ Other Medical Problems :				
❒ Prior Surgeries:				

SMOKING STATUS: ❒ Current : Year Start _____ How many packs a day _____
❒ Former: Year Start _____ Year End _____
❒ Never
❒ Decline

CURRENT MEDICATIONS: _____
_____
_____

MEDICATION ALLERGIES: ❒ NO ❒ YES **(Please list drug and reaction)**_____
_____

REVIEW OF SYSTEMS: Have you recently had changes or problems with:			
GENERAL ❒ Chronic fever ❒ Unexpected weight loss/gain ❒ Fatigue	**EARS/NOSE/THROAT** ❒ Hay fever/Allergies/Congestion ❒ Sinusitis ❒ Neck problems	**CARDIOVASCULAR** ❒ Chest pain/Discomfort ❒ Palpitations ❒ Shortness of Breath (exertion)	**GASTROINTESTINAL** ❒ Heartburn/Reflux ❒ Nausea/Vomiting/Diarrhea ❒ Hepatitis
RESPIRATORY ❒ Cough/Wheeze ❒ Shortness of Breath	**GENITOURINARY** ❒ Painful/Bloody Urination ❒ Leaking/Frequent Urination	**MUSCULOSKELETAL** ❒ Muscle/Joint Pain/Arthritis ❒ Back Pain	**SKIN** ❒ Rash ❒ Skin Cancer
NEUROLOGICAL ❒ Headaches / Migraines ❒ Weakness / Numbness	**PSYCHIATRIC** ❒ Anxiety/Stress ❒ Depression ❒ Insomnia	**BLOOD/LYMPHATIC** ❒ Anemia ❒ Leukemia / Lymphoma	**ENDOCRINE** ❒ Diabetes ❒ Thyroid
IMMUNOLOGIC ❒ Lupus ❒ Rheumatoid Arthritis	❒ **OTHER (Please explain):**		

PATIENT SIGNATURE: _____ **DATE:** _____

SIGNATURE OF RESPONSIBLE PARTY OR AGENT: _____ **RELATIONSHIP TO PATIENT:** _____

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Patient Conditions, Consent, Financial Agreements, Acknowledgement of Privacy Practices

Medical and Surgical Consent: The patient consents to medical & surgical treatment which may be performed, including dilating drops, diagnostic procedures, anesthesia, medical or surgical treatment or procedures rendered to the patient under the general and special instructions of the patient's physician, assistants, or designees. Patient also agrees that East Bay Eye Specialists may obtain electronic files from other healthcare providers or third party benefit payers of any results or information necessary to render treatment, such as health information, diagnostic test results or prescription medications.

Prescription RX Consent: The patient agrees that East Bay Eye Specialists may request and use their prescription medication history from other healthcare providers or third-party pharmacy benefit payors for treatment purposes.

Health Information Privacy / Release of Information (HIPAA) : We consider any information that concerns your health, healthcare, healthcare information, or payment for that care to be confidential and protected information. For purposes of determining liability for payment and obtaining reimbursement, the patient (or the patient's legal representative) agrees that East Bay Eye Specialists may disclose the patient's record, including their medical records, to any person, corporation, governmental body or other entity which is or may be liable, or which is involved in ruling on liability or who may assume or has assumed liability for all or any portion of charges including but not limited to: insurance companies, health care service plans, workers agencies. (A copy of the current HIPAA notice will be made available upon request and a copy of any amended notice of the HIPAA will also be offered.)

Eye Exams: Medicare, most supplemental & secondary and HMO insurances do not cover the refraction portion of the eye examination. If you are having a complete eye examination, you will be billed an amount for the **refraction** and this charge will not be covered by Medicare. If you have any questions, please call Medicare or ask our office staff for assistance. All other insured patients – please check with your insurance to confirm if the vision eye exam is a covered benefit.

Medicare Patients Only: Patient's Certification, Authorization to Release Information, and Payment Request: I certify that the information given to me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or other related Medicare claims. I request that payment of authorized benefits be made on my behalf.

Financial Agreement and Assignment of Health Plan Benefits: East Bay Eye Specialists accepts Medicare, Medi-Cal, and most PPO insurances. Patients with HMO insurances that require a prior authorization or referral **will be responsible for ensuring that authorization or referral has been obtained**. Patient (or patient's representative) hereby assigns to East Bay Eye Specialist any health insurance or health plan benefits payable by an insurer or health plan for the medical/surgical treatment provided to the patient. Patient (or patient's representative) signing below authorizes any health plan or health insurer to pay directly to East Bay Eye Specialists for such services. East Bay Eye Specialists will receive payment directly from insurance, but the patient is still responsible for any co-payment, deductibles, non-covered charges, denied claims, or the difference between what the insurance allows and what they pay. Therefore, East Bay Eye Specialists ask all patients with private insurance that are not accepted or patients that do not have any insurance coverage to please make payment at the time of service. In addition, all patients must notify East Bay Eye Specialists of any changes in insurance coverage immediately and provide the new insurance card (front & back). If there is a change in primary care physician information, patient is responsible for obtaining a new authorization or referral from their new physician. Insurance companies require East Bay Eye Specialists to collect copayments at the time of service. Waiver of co-payments may constitute fraud under state and local laws. **All copayments must be paid at the time of service.**

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I certify that I have read all of the above. I do hereby acknowledge that I am familiar and fully understand all of the information above, policies, terms, and condition of consent. I also understand if my health insurance plan does not authorize my visits, I will be responsible for the bill.

Patient's Signature:_____ Date: _____

Signature of Responsible Party or Agent: _____ Relationship to Patient: _____

"REFRACTION?"

Why do I have to pay?

If you've been to the eye doctor you may have heard the phrase, "Which is better: 1 or 2?" This is one of the most important parts of your eye exam: the **Refraction**. That is the part of the exam by which we determine whether you can be helped in any way by a new glasses prescription. It is also how we determine the best possible visual acuity and function of your eye, which is essential information for us to have as we assess your eyes and look for problems. ***A refraction must be performed if you wish to get a new prescription for glasses or to update your current prescription. This is the vision portion of your complete eye exam. Eyeglass prescription will be given.***

However, most **medical insurance companies including Medicare will not cover the refraction portion** of the eye exam even if the patient is being seen for a medical reason. These plans consider refraction a "vision" service not a "medical" service. Unless you are utilizing a separate vision insurance (such as VSP), you will be asked to pay for this service **in addition** to any co-payments, co-insurances or deductibles your plan may require at the time of your visit. As a courtesy and in accordance with our contract with Medicare and commercial insurances, we will submit a bill for the refraction and the accompanying exam to your insurance company. Should your plan pay us for the refraction, we will reimburse you accordingly.

Our fee for the refraction service, including an updated corrective eye glass prescription, is **$65.00.** We strive to provide accurate refractions. If you are unsatisfied with your refraction, we offer a no-charge recheck visit within the first 90 days of the refraction. (Contact Lens services & supplies are separate)

❒ **I have separate Vision Insurance**, I will have my Doctor perform my refraction along with my yearly eye exam through my Vision Insurance. (We only accept **VSP**) Please Provide:
VSP ID# _____ PRIMARY SUBSCRIBER NAME & DOB:_____

❒ **I CHOOSE TO HAVE** my Doctor perform my refraction along with my eye exam for a **$65.00** fee. (This fee is due at the time of service.)

❒ **I CHOOSE <u>NOT</u>** to have a refraction for a $65.00 fee.
(Please make sure to tell your eye doctor. In this case, a refraction will **NOT** be part of your comprehensive medical exam. Glass Prescription will not be given.)

I have read and understand the above information:

_____

Patient's Signature Date

_____

Signature of Responsible Party or Agent Relationship to Patient

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