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**

Patient Address:

_____

_____

Social Security #: _____/_____/_____

Marital Status : _____

Emergency Contact Info :

Name: _____

Relation: _____

Phone#: _____

Preferred for Text Messages
Primary Phone #: ( ) _____ - _____
(Mobile)

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

Email Address:_____

Occupation: _____

Employer: _____

RACE :	❒ Caucasian/White ❒ African American/Black	❒ Asian ❒ Hispanic/Latino	❒ American Indian ❒ Pacific Islander	❒ Middle Eastern ❒ Other : _____

ETHNICITY: ❒ Hispanic ❒Non-Hispanic

LANGUAGE: ❒ English ❒ Other:_____

Primary Insurance:_____

ID#:_____

Primary Care Physician: _____

Phone #: _____

Secondary Insurance: _____

ID #:_____

Referring Physician: _____

Phone #:_____

Do you have (VSP) Vision Service Plan ❒ YES ❒ NO

VSP ID: _____

Pharmacy: _____

Location: _____

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PATIENT MEDICAL HISTORY

Are you experiencing any eye problems? _____

_____

Family History/Member: ❒ Glaucoma ❒ Macular Degeneration ❒ Retinal Detachment

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	❒ Hard of Hearing
❒ Other Medical Problems and/or Prior Surgeries (Including Eye Surgeries):				
❒ ARE YOU **CURRENTLY** PREGNANT OR NURSING? ❒ YES ❒ NO				

SMOKING STATUS: ❒ Current : ❒ Every Day Smoker ❒ Some day Smoker
❒ Former
❒ Never

CURRENT MEDICATION NAMES:

_____

_____

_____

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: Most commercial insurance, HMO insurances, Medicare & Supplemental Insurances do not cover the **Refraction** (the vision portion) of the eye examination. If you are having a complete eye examination, you will be billed **$95.00** for the **Refraction** portion and this charge will not be covered. If you have any questions, please call your Commercial Insurance and/or Medicare or ask our office staff for assistance. Our office only accepts vision insurance, **VSP** (Vision Service Plan)

Form Fees: Please be informed that there is a $25.00 fee for the completion of **DMV Forms** and **Disability Forms**. The fee will be due upon receiving your form.

No Show/Cancellation Fees: All testing appointments which includes: Visual Fields, OCT Testing, Fundus Photos will require a No Show/Cancellation Charge of **$25.00** if you do not cancel 48 hour is advance of your appointment.

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.

Notice to Patients About Open Payments Database: For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page available on line at CMS website. The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public.

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.**

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: _____