Cullom Eye & LASER CENTER

Office Use Only:

Staff Initials: _____ Date: _____

Staff Initials: _____ Date: _____

Staff Initials: _____ Date: _____

PATIENT REGISTRATION FORM

Patient Information

Name:_____ Social Security #:_____
(Last) (First) (M.I.)

Mailing Address:_____
(Street or PO Box Number & Name) (City) (State) (Zip Code)

Birthdate:_____/_____/_____ Age:_____ Sex: Male Female Marital Status: S M D W

Home Phone:_____ Work Phone:_____ Cell Phone: _____

In case of emergency, name of contact: _____ Phone #: _____

Employer:_____Occupation:_____

Primary Care Physician:_____ Phone #:_____

Optemetrist:_____ Phone #:_____

Whom may we thank for referring you?:_____ Phone #:_____

Insurance Information

(It is YOUR responsibility to inform us of any changes in your coverage)

INSURANCE COVERAGE: VISION PLAN ___MEDICARE ___ NO INSURANCE ___ MEDICAID ___ OTHER:_____

Primary Insurance: _____ Secondary Insurance: _____

Policy Holder: _____ Policy Holder: _____

Social Security #: _____ Social Security #: _____

Date of Birth: _____ Date of Birth: _____

Relation to Patient: _____ Relation to Patient: _____

CONSENT TO TREAT / AUTHORIZATION TO RELEASE INFORMATION

I authorize the Physicians of Cullom Eye & Laser Center (Practice) to provide treatment and use my health information for treatment, payment, and healthcare operations, which includes submitting information to my insurance company for the purpose of processing claims. I am responsible for payment of services rendered to me by Practice. If I am under 18, parent / guardian requesting treatment assumes responsibility. Full payment is due at the time of service unless I am covered by an accepted insurance or third party coverage plan. I understand that if my account should ever require action by a collection agency in order to collect the balance owed, fees charged by these agents may be added to the balance due on my account. I hereby acknowledge and agree to accept the policies stated above.

Print Name: _____

Signature of patient\guardian:_____ Date: _____

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Patient Medical History

Patient Name: _____ **Birthdate:** _____/_____/_____

Are you having problems with any of the following activities? O Driving O Computer O Night driving O Seeing halos O Reading traffic signs O Crossword puzzles O Watching TV O Hazy vision O Problems from glare O Fine print O Other:_____

List any past eye injuries, surgeries, or problems: _____
_____

Alcohol Consumption: O Never O Socially O Moderate O Heavy **Smoking:** O Yes O No

Family History: (grandparents, parents, brother, sister, children)

O Glaucoma O Cataracts O Diabetes O Lazy eye O Macular degeneration O Strabismus O Cancer

Condition	1st Visit Yes	1st Visit No	2nd Visit Yes	2nd Visit No	3rd Visit Yes	3rd Visit No	4th Visit Yes	4th Visit No	If Yes, please give details
Fever/Weight Loss									
Diabetes/Thyroid									
Heart Problems									
High Blood Pressure									
Asthma/Emphysema									
Circulation Problems									
Hepatitis/HIV/AIDS									
Neurological (MS)									
Blood or Lymph									
Cholesterol									
Anxiety/Depression									
Kidney/Bladder									
Cancer									
Muscle/Joint									
Sleep Apnea									
Pregnant/Nursing									
Skin Condition									
Other									
Physician Signature									
Date									

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MEDICATION\ GLASSES & CONTACT LENSES

Patient Name: _____ **Birthdate:** _____/_____/_____

Do you currently wear glasses? O Yes O No

Do you currently wear contact lenses? O Yes O No

Please list any allergies (Foods, medications, latex, anesthesia):

_____

_____

Have you EVER taken any of the following medications? If yes, please list information below:

MEDICATION	DOSE	FREQUENCY
FLOMAX		
PLAQUENIL		
PREDNISONE		

Medication	1st Visit Yes	1st Visit No	2nd Visit Yes	2nd Visit No	3rd Visit Yes	3rd Visit No	4th Visit Yes	4th Visit No
Physician Signature								
Date								

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PATIENT AGREEMENTS:

OFFICE USE ONLY:

- ☐ Patient does not want to receive a copy of this document
- ☐ Patient requested and was provided a copy of this document.
- ☐ No responsible Person Available.
- ☐ **Staff Initials: _____ Date:_____**

Refraction Charges

A refraction is a diagnostic test used to determine the patient's visual abilities. A series of lenses are presented to determine which prescription provides the sharpest and clearest vision. This test is performed during your annual eye exam or if there has been a recent change in your vision. It is necessary for the physician to perform this test in order to determine the best visual acuity, as well as, evaluate potential eye diseases.

Some insurance companies, including MEDICARE, do not cover the refraction test

The usual charge for this service is $55. If your insurance does not cover this test, Cullom Eye & Laser Center offers a time-of-service discount of $20.00 Therefore, if you pay today, your out-of-pocket expense is only $35. If you cannot pay today, your charge will be sent through our billing service and you will be billed for the full fee of $55.

Initials: _____ Date: _____

Return Appointments

I understand that I may be given a return appointment in order to follow-up on my eye status or condition. In the event that, for any reason, I do not keep that appointment and do not promptly reschedule, I agree not to hold Cullom Eye & Laser Center, it's Physicians, and/or staff responsible for any resulting consequences. Appointments cancelled with less than 24 hours' notice may be charged to my account.

Initials: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

I am aware of and/or have received Riverside's Notice of Privacy Practices brochure. Upon receiving an inquiry as to the presence or condition of the Patient, RMG may (unless otherwise requested by the Patient, next of kin, or physician) release at its discretion; the name, address, age, sex, general nature of injuries, and/or the general condition of the Patient. I understand that a separate written consent is required for me and/or I the person(s) listed below to receive copies of my written medical records. However, I hereby give permission to my physician & office personnel to verbally discuss any and all of my medical condition(s) with the following person(s).

_____ _____

Print Individual Name & Phone Number Print Individual Name & Phone Number

_____ _____

Print Individual Name & Phone Number Print Individual Name & Phone Number