INFINITY EYE CARE CENTER - PATIENT REGISTRATION

Date: _____ Sex: M F Exam for: Glasses Contact lenses Office Visit

Last Name: _____ First Name: _____ M.I._____

Street: _____City: _____ State: _____Zip:_____

Social Security #: _____-_____-_____ Date of Birth: _____

E-mail Address: _____

Home Phone:_____ Cell Phone: _____

Employer: _____ Work Phone: _____

Family Physician: _____Phone: _____

When did you last see an Eye Doctor? _____Years ____Months Doctor or Clinic Name_____

WHAT IS THE MAIN REASON (S) YOU ARE VISITING TODAY:

_____

_____

_____

Who may we thank for referring you to our office: _____

INSURANCE INFORMATION

Do you have vision insurance? Yes No

Primary Insurance Carrier

Plan Name:_____

Policy Holder:_____

DOB:_____SS#:_____

Relationship to Patient:_____

Member ID #:_____

Group No:_____

Effective Date:_____

Do you have health insurance? Yes No

Secondary Insurance Carrier

Plan Name:_____

Policy Holder:_____

DOB:_____SS#:_____

Relationship to Patient:_____

Member ID #:_____

Group No:_____

Effective Date:_____

Assignment of Benefits: I authorize payment directly to the above named provider of medical expense benefits otherwise payable to me but not to exceed my indebtedness to said provider for any services furnished to me by that provider.

Patient Responsibilities: Co-pays & deductibles are required on date of service. We will bill your insurance but can't assure payment. You are fully responsible for payment. Dr. Smith O.D. and Associates use an outside billing agency to perform the duties of billing, submission, and retrieval of insurance payments. We will bill all exams to your appropriate carrier, but if they do not pay the claim then you will be required to submit payment for services performed. If you use your plan benefits for spectacles and also want contact lens examination then additional fees for the contact lens examination will be due at time of service.

Signature:_____ Date:_____

For office use: Insurance Authorization #:_____ Co-pays:_____

Has deductible been met Y N: What is deductible:_____ Amount met so far:_____

Eye diseases, conditions, or problems you currently have or have been diagnosed with:
(Please circle any that apply)

Astigmatism Cataracts Glaucoma Macular Degeneration Retinal Detachment

Diabetic Retinopathy Dry Eye Syndrome Other: _____

Using Glasses? No Yes (Circle type) Single vision Bifocal Trifocal Progressive Store-bought readers

Contact Lenses: Never worn Interested in Wearing Y N Current Wearer Worn in the past

Your General Health	**Your Eye History**	**Family Health**	**Your Vision Needs**	**Options**
Do you have or ever had problems with...	***Have you had....***	***Has anyone in your family had...***	***Do you do...***	***Do any of the following appeal to you...***
❑ Allergies	❑ Eye Disease	❑ Diabetes	❑ Crafts/Sew	❑ AntiGlare Lenses
❑ High Blood Pressure/Heart	❑ Eye Surgery	❑ Glaucoma	❑ Computer	❑ Contact Lenses
❑ High Fever	❑ Glasses	❑ Blindness	❑ Read Books	❑ Lenses that Darken
❑ Diabetes	❑ Contact Lenses	❑ Cataracts	❑ Golf	❑ No-Line Bifocals
❑ Stomach or Bowels	❑ Blurred Vision	❑ Crossed Eyes	❑ Team Sports	❑ Safety Glasses
❑ Kidney or Genitourinary	❑ Crossed Eyes	❑ Lazy Eye	❑ Music	❑ Scratch Resistant Lenses
❑ Ears, Nose, Mouth, Throat	❑ Lazy Eye	❑ Macular Degeneration	❑ Shooting	❑ Sunglasses/Sunclips
❑ Blood or Lymph	❑ None of the above	❑ Retinal Detachment	❑ Racquet Sports	❑ Thinner Lenses
❑ Immune Disorder	**SOCIAL HISTORY**	❑ None of the Above	❑ Skiing	❑ Lighter Weight Lenses
❑ Skin Disease	***Do you.....***		❑ Biking	❑ TV Glasses
❑ Arthritis or Muscular	❑ Smoke now		❑ Fishing	❑ Computer Glasses
❑ Neurological Disorder	❑ Consume Alcohol		❑ Woodshop	
❑ Depression or Psychiatric	❑ None of the above		❑ Water Sports	
❑ Breathing or Respiratory			❑ None of the above	
❑ None of the above				

If you checked any box above and would like to add any information that may help the doctor, please do so below.

_____

_____

_____

_____

DO YOU HAVE ANY ALLERIGES TO MEDICINES: _____

List any medication you are taking now – *Prescription or Over-the-Counter* _____

_____

_____

_____

Please be assured that all of your personal information, examination findings, and specialized test results will not be discussed with anyone or released without your consent. Our office strives to protect you and your information as it relates to HIPPA. If you have any questions regarding the HIPPA regulations please ask a staff member.

Thank you for taking the time to complete this form so that we may address your visual needs.

The highest compliment you can give us is to refer your family and friends.

Sincerely, Dr. Kevin Smith, O.D. & Staff