InSight
Family and Pediatric Eye Care
. . . an eye for caring

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PATIENT REGISTRATION & MEDICAL HISTORY FORM

Date: _____ Full Name: _____ Date of Birth___ /___ /___
Street Address: _____City_____Zip Code_____
How would you prefer we contact you? [C] __ [H] __ [W] __ Email __
Cell Phone: _____ Home Phone: _____ Work Phone: _____
We communicate fastest by Email: _____ @ _____ . _____
Adult's Insurance Policy Holder's SSN: __ __ __ - __ __ - __ __ __ __
Employer: _____
Spouse or Parent Contact Phone Number: _____

Adult with minor patient: You are the patient's: ❑ Mother ❑Step-mother ❑Father ❑Step-father

How did you choose our office for your needs? ❑ Saw building ❑ Insurance List ❑ Website
❑ Friend: Name: ❑ Referring Doctor: Name:

Insurance (*Please provide **all** cards)*

Vision Insurance: ❑ EyeMed ❑ VSP ❑ Superior ❑ Community ❑ None
Primary Medical Insurance: ❑ Medicare ❑ BCBS ❑ Medicaid ❑ UHC ❑ Aetna ❑ Mutual of Omaha
Secondary Medical: _____
Adult Policy Holder's Name:_____DOB_____SSN__ __ __ - __ __ - __ __ __
Relationship to Insured: ❑ Self ❑ Parent ❑ Child ❑ Spouse
How will you settle your account today? ❑ Cash ❑ Debit ❑ Credit Card ❑ Check

Medical History

Primary Care Provider:_____ Location:_____

Medications:_____

Birth History _____ weeks _____ lbs_____ oz. Twin: ❑ yes ❑ no

Would you like information on: ❑ Advanced, self-pay testing if your child has a history of prematurity?

Do you have: Hypertension **Y N** High Cholesterol **Y N** Acid reflux **Y N** Eczema **Y N** Thyroid problems **Y N**

Allergies to Medications: _____ Do you smoke: ❑ no ❑ yes: since _____

Are you: ❑ pregnant ❑ breastfeeding Have you had gestational diabetes? **Y N**

If you've had cancer, please list type: _____ Treated how? ❑ Radiation ❑ Chemo ❑ Surgery

If you are diabetic: # of years treated _____ Last HbA1C _____ Last Vitamin D result _____

Does a parent or sibling have: ❑ Diabetes ❑ Eye turn ❑ Lazy eye ❑ Glaucoma ❑ Macular Degeneration

Would you like information on: ❑ Advanced, self-pay testing if you have a family history of diabetes?

Do you have trouble seeing at night? **Y N** Do you use artificial tears? **N Y:**brand _____

Please note how your eyes feel after looking at a computer screen: _____

Please note how your glasses work for you out in the sun: _____

Do you spend time outdoors? ❑ Golfing ❑ Fishing ❑ Hunting ❑ Racing ❑ Shooting ❑ Other_____

Would you like information on: ❑ Contacts ❑ Glasses ❑ Myopia control ❑ LASIK

OVER →

Same Day Cancellation / No-Show Policy

Many offices overbook to compensate for same day cancellations and no-shows. This results in rushed, poor care. We pride ourselves on giving thorough exams which require time. In order to maintain this environment, *please note a same day cancellation or no-show will require a **$50 credit card payment** to reschedule.*

Signature: _____ Date: _____
(Patient or Parent/Guardian if patient is a minor)

Insurance Filing Timeline / Collections Policy

Prior to your appointment, we invest significant time checking medical and vision benefits on your behalf. However, we need your help to be successful. You can help us prevent most payment issues by:

- Providing **ALL** insurance policies.
  (ex. You actually have two policies, one through you, one through your spouse)
- Identifying the policy holder.
  (ex. We file under your name and social security number but it is actually your spouse's policy).
- Insurance status: **who pays when**
  (ex. Medicare as given as primary but you work full-time and BCBS is primary)

If we submit a "clean claim" (one with correct demographic information and coding) three times over a 90 day period and have not received payment from your insurance carrier, the balance becomes your responsibility. I understand that I am responsible for payment of all charges. As a courtesy, my medical insurance or vision plan will be billed for me. It is my responsibility to pay any deductible, copay or any other balance not paid by my insurance company or vision plan. I authorize third party benefits to be paid directly to the provider.

Signature: _____ Date: _____
(Patient or Parent/Guardian if patient is a minor)

Notice of Privacy Practices Acknowledgement and Consent

The Notice of Privacy Practices provides you information how we may use and disclose protected health information about you. You have the right to review our Notice before signing this consent. It states that we will use and share your health records: for treatment, to bill for the services provided and for health care operations to run our business and to comply with the law. You have the following rights with respect to your health records: to look at and receive a copy, to receive a list of whom we have given your health records to, to ask us to correct a mistake in your health records, to ask that we not use or share your health records and to ask us to change the way we contact you. You have the right to request that we restrict how protected health information about you is disclosed for treatment, payment or health care operations. We are not required to agree to the requested restriction, but if we do, we are bound by our agreement. By signing this form you acknowledge that you have received access to InSight Family and Pediatric Eye Care's Notice of Privacy Practices. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Signature: _____ Date: _____
(Patient or Parent/Guardian if patient is a minor)