

PATIENT REGISTRATION & EYE/HEALTH HISTORY

NAME (Mr/Mrs/Ms) _____ TODAY'S DATE _____

ADDRESS _____ AGE _____ BIRTH DATE _____

CITY _____ STATE _____ ZIP _____ HOME PHONE _____

GENDER MALE FEMALE WORK PHONE _____

EMAIL ADDRESS _____ CELL PHONE _____

OCCUPATION (GRADE IF STUDENT) _____ EMPLOYER (SCHOOL) _____

SSN# _____ HOBBIES/SPORTS _____

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

REASON FOR TODAY'S VISIT? _____

IF PATIENT IS A MINOR:

PARENT/GUARDIAN _____ / / _____

LAST NAME FIRST NAME MIDDLE INITIAL SOCIAL SECURITY #

DATE OF BIRTH _____ HOME PHONE _____ CELL PHONE _____

EMPLOYER _____ EMPLOYER PHONE _____

LAST EYE EXAM _____ EYE DOCTOR/CLINIC _____

GENERAL PHYSICIAN/CLINIC _____ LAST PHYSICAL _____

MEDICATIONS YOU ARE TAKING _____

DRUG ALLERGIES _____

Most insurance companies now require us to ask the following questions of patients 14 years of age and over. We apologize for the intrusion.

DO YOU:	YES	NO	DTA <i>(decline to answer)</i>
Smoke	_____	_____	_____
Drink Alcohol	_____	_____	_____
Have problems with Substance Abuse	_____	_____	_____

I prefer to be contacted via: Home Phone Cell Phone Work Phone Email Regular Mail

Preferred Language: _____ English _____ Spanish

Race: _____ African American _____ Caucasian _____ Hawaiian _____ American Indian
 _____ Hispanic/Latino _____ Asian _____ Indian _____ Multiracial _____ Arab

Ethnicity: _____ Hispanic/Latino _____ Not Hispanic/Latino

PRIMARY INSURANCE

Name of Insurance Company: _____

Subscriber's Social Security Number: _____

Policy Number: _____ Group Number: _____

Subscriber's Name: _____ Subscriber Birth Date: _____

Subscriber's Employer: _____

SECONDARY INSURANCE

Name of Insurance Company: _____

Subscriber's Social Security Number: _____

Policy Number: _____ Group Number: _____

Subscriber's Name: _____ Subscriber Birth Date: _____

Subscriber's Employer: _____

— AUTHORIZATION AND PAYMENT AGREEMENT —

INSURANCE COMPANY _____ ID# _____

I request that payment of authorized insurance benefits be made directly to Rock Island Optometric/Mercer County Family Eyecare on my behalf. I also authorize the release of any necessary information to process insurance claims and permit my signature to be kept on file for future claims.

As the responsible party, I agree to be ultimately responsible for any balance incurred in this office, regardless of insurance coverage. Accounts that remain unpaid for 90 days will be subject to collection fees and expenses, including reasonable attorneys' fees, court costs plus all legal fees if incurred for collection. A service charge will apply to any returned checks.

I understand that any benefits quoted to me are not a guarantee of payment by my insurance company, and that the final determination of payment will be made once the claim is processed.

SIGNATURE _____ **DATE:** _____

ACKNOWLEDGMENT OF RECEIPT

I acknowledge that I received a copy of Rock Island Optometric Center's Notice of Privacy Practices.

Patient Name _____

Signature _____ Date _____