

Name: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_

**Past Eye Problems**

**Prior Eye Surgery**

**Eye Medications**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Past Medical History**

**Family History**

**Other Medications**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

|                      |     |                      |
|----------------------|-----|----------------------|
| <i>Condition</i>     |     | <i>family member</i> |
| Cataracts            | Y/N | _____                |
| Glaucoma             | Y/N | _____                |
| Macular Degeneration | Y/N | _____                |
| Crossed/Lazy Eye     | Y/N | _____                |
| Retinal Detachment   | Y/N | _____                |
| Diabetes             | Y/N | _____                |

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Past Surgical History**

**Social History**

**Allergies**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you consume alcohol?      Y/N

Do you use recreation drugs?      Y/N

If **YES**, please Specify: \_\_\_\_\_

Do you currently smoke cigarettes?      Y/N

If **NO**, did you previously smoke?      Y/N

If so, when did you quit? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Review of Systems: (please select all that currently apply)**

- Artificial Joints in Last 2 Years**
- Jaw Pain**
- Scalp Tenderness**
- Fever**
- Chills**
- Weight Loss**
- Stuffy Nose**
- Ear Ache**
- Cough**
- Dry Mouth**
- Rapid Heart Beat**
- Congestion**
- Wheezing**
- Shortness of Breath**
- Upset Stomach**
- Diarrhea**
- Constipation**
- Incontinence**
- Joint Pains**
- Stiffness**
- Rash**
- Headache**
- Insomnia**
- Diabetes**
- Bleeding**
- Anemia**
- Hives**
- Depression**
- Stroke**
- Anxirty**
- Arthritis**
- Allergies**
- High Blood Pressure**
- Allergy to Adhesive**
- Allergy to Lidocaine**
- Blood Thinners**
- Defibrillator**
- Flomax**
- MRSA**
- Pacemaker**
- Rapid Heart Beat with Epinephrine**
- Pregnancy or Planning Pregnancy**
- Pseudoexfoliation Syndrome**
- Steroid Responder**

## Patient Registration

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Preferred Name: \_\_\_\_\_ Birth Sex: Male / Female

Gender Identity: Male/Female/Non-Binary Preferred Pronouns: He/She/They

Home Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Person to notify in case of emergency: \_\_\_\_\_

Phone number(s): \_\_\_\_\_ Relationship: \_\_\_\_\_

Primary Insurance Company: \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_

I certify that I (or my dependent) have insurance coverage as stated above and agree to have insurance payments made directly to Central Vermont Eye Care to be applied to my account for services rendered. **I understand that I am financially responsible for all charges incurred in the event that my insurance denies payment.** I am aware there may be additional collection and/or attorney's fees if my account is referred for collection. For patients covered by Medicare the patient will be responsible for 20% of the Medicare allowable charges plus any deductibles, co-insurance and uncovered charges that apply.

\_\_\_\_\_  
Signature of Patient/Parent/Guardian

\_\_\_\_\_  
Printed Name

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**AUTHORIZATION FOR USE OF DISCLOSURE OF PROTECTED HEALTH INFORMATION:**

I authorize my physician and/or administrative and clinical staff of Central Vermont Eye Care to disclose general medical information and other protected health information to the following persons and/or entities listed below. If no one is listed below, protected health care information will not be disclosed except in those situations described in the Notice of Privacy Practices.

Name and relationship of person(s) who you wish to allow access: (e.g., your spouse, son, daughter, friend).

**Name of Person or Entity**

**Relationship**

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Signature

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Date

## NOTICE OF FINANCIAL AND PRIVACY POLICIES

At Central Vermont Eye Care, we are committed to providing you with the highest level of service and quality care. If you have medical insurance, we will help you receive your maximum allowable benefits. To this end, we ask for your assistance and acknowledgment of our financial policy. Ultimately, any and all financial liability rests with you - the patient.

Our office participates with most major health insurance plans. *We do not, however, participate with any vision plan (VSP, Davis Vision, EyeMed, etc.).* Your visit will be covered by your medical insurance if you are here for management of a **medical condition** (i.e., cataract, diabetes, dry eyes). Most medical insurances do not cover the cost for refraction (the prescription-finding portion of the exam). You may be asked to pay the \$50 refraction fee at the time of your visit. For more information regarding refractions, please see our policy at the front desk.

If your visit today is for routine eye care (i.e., update in glasses or contacts) for a **“non-medical” condition** (near-sightedness, far-sightedness, etc.), it is unlikely that your medical insurance will cover the cost of the exam. For this reason, we are offering you the option of paying the same amount that our non-insured patients do at the time of their visit: \$159, self-pay. If you elect this option, you will be asked to pay at the time of your visit.

It is the patient’s or guardian’s responsibility to:

- be familiar with the benefits and obligations of your plan, including copays, co-insurance and deductibles.
- bring all current insurance cards to all visits.
- provide our office with up to date contact information.
- be prepared to pay your co-pay at each visit.

Available for viewing at the front desk is a notice of privacy practices as mandated by the Health Insurance Portability and Accountability Act of 1996, otherwise known as HIPPA. This notice describes how medical information about you may be used and disclosed, how you can get access to it, and lists your rights under this law.

***I understand the above statements regarding the financial policy and privacy practices used by Central Vermont Eye Care.***

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Signature of Patient or Guardian

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Date

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Printed Name