Name:_____ **Primary Care Physician:**_____

Date of Birth:_____ **Preferred Pharmacy:**_____

Past Eye Problems

_____

_____

_____

_____

Prior Eye Surgery

_____

_____

_____

_____

Eye Medications

_____

_____

_____

_____

Past Medical History

_____

_____

_____

_____

_____

_____

Family History

Condition		*family member*
Cataracts	**Y/N**	_____
Glaucoma	**Y/N**	_____
Macular Degeneration	**Y/N**	_____
Crossed/Lazy Eye	**Y/N**	_____
Retinal Detachment	**Y/N**	_____
Diabetes	**Y/N**	_____

Other Medications

_____

_____

_____

_____

_____

_____

Past Surgical History

_____

_____

_____

_____

_____

_____

Social History

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? _____

Allergies

_____

_____

_____

_____

_____

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

_____ _____

Signature Date

NOTICE OF MEDICARE BILLING AND PRIVACY PRACTICE

NAME:_____ DOB:_____

MEDICARE ID NUMBER:_____

SECONDARY INSURANCE:_____

SECONDARY INSURANCE ID #_____GROUP#_____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Central Vermont Eye Care for any services furnished to me by their providers. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance coverage is indicated in item 9 of CMS 1500 claim form or elsewhere on other approved claim forms or electronically submitted claims, my signature releasing of the information to the insurer or agency shown. In Medicare assigned cases, Central Vermont Eye Care agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is only responsible for the deductible, coinsurance, and non-covered services. Co-insurance and deductible are based upon the charge determination of the Medicare carrier.

An example of a non-covered charge is the eye refraction fee. If a refraction is preformed, the $50.00 charge is payable at the time of visit. For more information about refractions ask for our policy at the front desk.

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.

_____ _____

Signature of patient/parent/guardian Date

_____

Printed Name