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)

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

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 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 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, etc.). Most medical insurances do not cover the cost for a refraction. **If a refraction is performed, the $50.00 charge is payable at the time of visit**. Eye refractions are necessary in order to write glasses prescriptions and/or to see if improvement in vision is possible. Refractions are part of annual eye exams, but may be done more frequently when necessary.

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: $175, self-pay. If you elect this option, you will be asked to pay at the time of your visit, and your visit will NOT be submitted to insurance.

It is the patient's or guardian's responsibility to be familiar with the benefits and obligations of their plan, including copays, co-insurance and deductibles, and to be prepared to pay their co-pay and other incurred fees (i.e. refraction) at each visit. We also ask patients to bring their current insurance cards to all visits and to provide our office with their current contact information.

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 HIPAA. 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.

_______________________________   ______________

Signature of Patient or Guardian   Date

____

Printed Name