

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)**

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

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 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: \_\_\_\_/\_\_\_\_/\_\_\_\_

## NOTICE OF MEDICARE BILLING AND PRIVACY PRACTICE

NAME: \_\_\_\_\_

DOB: \_\_\_\_\_

*I request that payment of authorized Medicare benefits be made 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 for 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 on the CMS 1500 claim form or elsewhere on other approved claim forms or electronically submitted claims, my signature below releases 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 I am only responsible for the deductible, co-insurance, 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 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.

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/parent/guardian

\_\_\_\_\_  
Date

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

**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