AMERICAN EYE CARE CENTER

Registration Form

PATIENT INFORMATION:

Full Name:____

Date of Birth:_________________ Sex:_________ Social Security:___________________

Cell:____________________ Home:____________________ Work:____________________

Email:____

Address:____

____

Occupation:_________________________________

Pharmacy Information:

Pharmacy Name:_________________________________ Phone :_______________________

Address:____

INSURANCE INFORMATION:

Primary Insurance:

Name:____________________ Member ID:_____________________ Group: ______________________

Secondary Insurance:

Name:____________________ Member ID:_____________________ Group: ______________________

Primary Insurance Guarantor:

Full Name:____ Relation:__________________________

Date of Birth:_________________ Sex:_________ Social Security:___________________

Cell:____________________ Home:____________________ Work:____________________

Email:____

Address:____

____

I authorize the release of any medical information necessary to process this claim and authorize payment of medical benefits from any insurance company to Hameed Peracha, MD for his services. The undersigned agrees to pay all charges for services rendered and do hereby become legally responsible for any uninsured balance. In the event of collection procedures are necessary, all costs including attorney's fee will be patient's responsibilities.

Signature:____ Date:_______________________

REVIEW OF SYMPTOMS

Referring Doctor:_______________________________ Date of Last Eye Exam:_____________________

Do you currently have any problems in the following areas? If "YES", please provide details in the space below.

Constitutional Symptoms:

Weight Loss	YES/NO	Eye Pain/Soreness	YES/NO
Loss of Vision	YES/NO	Chronic Infection	YES/NO
Blurred Vision	YES/NO	Fluctuating Visual Acuity	YES/NO
Distorted Vision (Halos)	YES/NO	Tired Eyes	YES/NO
Loss of Side Vision	YES/NO	Chronic Cough	YES/NO
Double Vision	YES/NO	Dry Throat/Mouth	YES/NO
Dryness	YES/NO	High Blood Pressure	YES/NO
Mucous Discharge	YES/NO	Heart Attack	YES/NO
Redness	YES/NO	Chronic Bronchitis	YES/NO
Sandy or Gritty Feeling	YES/NO	Asthma	YES/NO
Itching	YES/NO	Muscle Pain	YES/NO
Burning	YES/NO	Joint Pain	YES/NO
Foreign Body Sensation	YES/NO	Diabetic	YES/NO
Excess Tearing/Watering	YES/NO	Thyroid	YES/NO
Occasional Tearing	YES/NO	Allergy	YES/NO
Glare/Light Sensitivity	YES/NO		

Please use the area below for further details:

____

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____

____

PAST MEDICAL HISTORY

List of Medications: ____

____

List of Major Illnesses or Injuries: ____

____

Have you had Crossed Eyes, Lazy Eye, Drooping Eyelid or Prominent Eyes? _________________________

____

FAMILY HISTORY

	YES	NO	Relationship
Blindness			
Glaucoma			
Macular Degeneration			
Retinal Detachment			
Diabetes			
Heart Attacks			

SOCIAL HISTORY

Do You Drive YES/NO
Do You have Visual Difficulty when Driving? YES/NO
Do You have Problems with Nigh Vision? YES/NO
Do You wear Contacts? YES/NO
Do You Wear Glasses? YES/NO
If YES, For How Long? ________________
Have you ever been in contact with a person who has a Sexually Transmitted Disease? YES/NO

Do You Drink Alcohol? YES/NO
How Many Glasses Per Day?__________
Do You Smoke? YES/NO
How Many Packs a Day? _____________
Have you ever had a blood transfusion? YES/NO

History Review: No Change Additions as noted above

Physician Signature: ____Date:_________________

<u>OFFICE POLICIES & FEES</u>

Welcome to our practice . We would like to provide you the best and most comprehensive care. Please read our office policies so we may better serve you.

<u>REFERRAL</u>: Your insurance may require you to have a referral from your primary care physician. If your plan requires a referral it is your responsibility to obtain it from your primary care doctor and bring it to the day of appointment.

<u>MEDICAL RECORD:</u> Patients requesting copies of their medical record must contact the office at least one week in advance, personally pick up the copied records and sign a release/pick up form. We charge $2.00 per page and $10.00 handling fee for all copied records.

<u>RETURENED CHECKS</u>: You will be charged a $15.00 for any returned/cancelled checks.

<u>CO-PAYMENTS:</u> Co-payments and deductible must be paid at the time of the office appointment upfront.

<u>PRESCRIPTION REFILL:</u> Please allow at least 24 to 48 hours to complete your request.

<u>RESULTS:</u> Results from procedure will be discussed during follow up visit.

<u>REFRACTION FEE:</u> Refraction is an essential part of an eye examination that will help us determine if a patient is in need for glasses. These measurements are not covered by most insurances .If this service is not cover ,there will be a $44.00 fee and you will be responsible for this payment

<u>APPOINTMENTS & CANCELLATIONS:</u> Patients arriving more than 25 mins late will be accommodated based on the schedule. Please give us the courtesy of cancelling office appointment at least 24 hours in advance, $25.00 will be billed for no show . Please provide two weeks' notice for cancellation of any schedule surgery, failure to do so will result in $200.00 fee and will be billed to you.

Your signature below confirms that you have read and agree to the above.
A copy will be provided if you request.

Print Name :____ Date:_________________

Signature:____

PATIENT CONSENT FORM

Our notice of Privacy Practices provides information above how we may use and disclose protected health information about you. The notice contains a Patients Right section describing your right under the law. You have the right to review our Notice before signing this consent. The terms of our Notice may Change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment and health operations. We are not obligated to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for the treatment, payment and health care operations. You have the right to revoke this consent, in writing, signing by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The practice provides this form with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).
The Patient understand that:

- Protected health information may be disclosed or used for treatment, payment and health care operations.
- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.
- The practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the use of their information, but the practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then erase.
- The practice may condition treatment upon the execution of this consent.

1. May we call your home/cell/work to confirm future appointment? YES/NO
2. Is there someone you want your information to be discussed with, in case we can't get in contact with you? YES/NO

If "YES" , Then Full Name: ___________________________

Cell : ___________________________

Print Name:____ Date:______________________________

Signature: ____