The Eye Site
at copley circle
family eye care

New Patient Registration

(Please fill out all 4 pages.)

Federal regulations require that we confirm the identity of patients using insurance with a photo ID.

Name_____ **Date**_____
Last **First** **MI**

Address: _____
Street **Apt**

_____
City **State** **ZIP**

Gender □ **Female** □ **Male** **Date of Birth** _____

SSN _____ **How would you prefer to be contacted?**
□**phone** □**email** □**text**

Email_____

Best phone number to reach you_____

Alternate number_____

Your Employer (or school)_____

Vision Plan **Medical Insurance**

_____ _____
Company **ID** **Company** **ID**

To help speed the processing of your claims please let us make a copy of your insurance cards. If you are not the primary insured, please complete the information below:

Name of insured:_____ Date of birth_____
Address: □ Same as above, or

_____
_____

Employer:_____ SSN_____

The primary insured is the patient's □ spouse □ parent

Medical History

Please answer the questions as completely as you can. The doctor will review your answers with you and discuss any eye health concerns you may have that are not covered here.

Are you in general good health? If not, what are your major concerns?

_____

_____

_____

Do you smoke or use tobacco? □ Yes □ No

Do you drink alcohol? □ Never □ Occasionally □ 1-3 times per week □ Daily

Are you currently taking and prescription medications?

If you are, please list them: _____

_____

_____

_____

Do you have problems in any of these areas?

Gastrointestinal (Stomach, intestines, etc.)	□ Yes □ No
Genitourinary	□ Yes □ No
Blood or lymph	□ Yes □ No
Serious Headaches	□ Yes □ No
Nervous system	□ Yes □ No
Endocrine disorders (diabetes, thyroid)	□ Yes □ No
Respiratory	□ Yes □ No
Mental health	□ Yes □ No
Cardiovascular (heart)	□ Yes □ No
Skin	□ Yes □ No
Ear/nose/throat	□ Yes □ No
Musculoskeletal	□ Yes □ No
Allergies/immune system	□ Yes □ No

Is there a history in your family of any of the following?

□ Diabetes	**□Glaucoma**	**□High blood pressure**
□ Blurred vision	**□Retinal detachment**	**□Cataracts**

Have you had any type of eye surgery?

Do you have problems with □ dry eyes □ blurred vision?

Do you wear glasses or contact lenses?

Are you having any vision problems at this time?

Doctor's notes:

By_____

Assignment, Release, and Acknowledgement

I authorize payments of benefits directly to The Eye Site for services rendered. I also authorize release of any medical information that may be required in determination of such benefits. I understand some services may require approval of my primary care physician for coverage and that if I do not obtain that approval I am financially liable for the services. I understand that my insurance carrier(s) may not cover some services and products and benefit information does not constitute approval for payment.

Deductibles and fees not paid by my insurance carrier will be my responsibility.

I acknowledge that I have received a copy of The Eye Site's NOTICE OF PRIVACY ACT (also known as the HIPAA Policy).

Signature of patient_____

Or guardian _____

Please tell us how you found us:

□ **We are listed as a provider by your insurance company**

□ **You were referred to us by family or friends**

□ **Advertising in _____**

□ **On an Internet search**

□**Yellow Pages**

□ **Other_____**

For your security:

The Eye Site will not use any information collected from you for any purpose other than to satisfy your eye care needs and file claims with your insurance carrier. We will not give or sell your information (name, address, DOB, SSN, etc.) to any third party.

In addition, The Eye Site does not retain any credit or debit card information belonging to our patients. If you pay by card, be assured that we will not make or keep any card information in our files.