Dear Patient,

It is a pleasure to welcome you to Regional Eye Associates.

We dedicate ourselves to enhancing the quality of life for every individual we treat by helping each to see his or her best, and by preserving and protecting our patients' vision and eye health throughout life.

It is extremely helpful for us to know the reason for your visit and your medical history prior to your appointment with us. For this reason, we ask that you complete the enclosed questionnaires and bring them with you to your appointment. Additional information to bring to your visit includes insurance card(s) and current eye glass or contact lens prescriptions.

Again, welcome to Regional Eye Associates!

Sincerely,

Doctors and Staff

Our Office Policy Regarding Patient Financial Responsibility

We are committed to providing you with the best possible medical care, regardless of whether or not you have health insurance. In order to achieve this goal, we need your assistance and your understanding of our financial policy.

Payment for services is due at the time services are rendered, unless we participate with your insurance. As a courtesy, we will bill participating provider insurance on the patient's behalf. Your co-pay, any deductible, or any amount not covered by your insurance is due at the time of your visit. All cosmetic procedure fees must be paid in full before the procedure is performed. The fees that we charge are within the usual range for our area and specialty.

If you have an insurance plan that requires a referral, you will need to contact your primary care physician and have them forward a referral to our office. We may not be able to see you if a referral is not on file with our office by the scheduled appointment date.

If we are not a participating provider with your insurance or if you do not have insurance, you will be expected to pay the entire fee, in full, at the time of the visit. If we do not participate with your insurance, we can provide you with information for you to submit to your insurance carrier.

An eye examination may or may not be covered by insurance. Routine (normal) eye exams are not a covered service of Medicare and many other insurance companies. If there is no medical problem, such as glaucoma or cataracts, then the exam is considered "routine" and is not a covered benefit. Please consult with your insurance carrier.

One of the most important parts of your eye exam today is the refraction. That is the part of the exam by which we determine whether you can be helped in any way by a new glasses prescription. It is also how we determine the best possible visual acuity and function of your eye, which is essential medical information for us to have as we assess your eyes and look for problems. It is NOT a covered service by Medicare and many other insurance plans. These plans consider refraction a "vision" service not a "medical" service. Our office fee for the refraction is $25 and unless your plan automatically covers the refraction charge, this fee is collected at the time of service in addition to any copayment your plan may require. Should your plan pay us for the refraction, we will reimburse you accordingly.

Payment options: Cash, Check, Debit cards, Visa, MasterCard, and Discover.

We will gladly discuss any questions you have regarding our billing and your insurance. Please call and speak with a receptionist if you have any questions regarding our policies.

PATIENT REGISTRATION

PATIENT INFORMATION				
Patient Name: First Middle Last		Date of Birth:	Social Security Number: - -	
Home Address: Street (no post office box)		City	State	Zip
Home Phone: ( ) -	Sex: (circle one) M F	Marital Status: (circle one) Single/Married/Divorced/Widowed	E-mail Address:	
Employer Name:		Occupation	Employer Phone: ( ) -	
Employer Address: Street (no post office box please)		City	State	Zip
GUARANTOR INFORMATION (the person responsible for the patient's account; **complete only if different from patient**)				
Guarantor Name: First Middle Last		Date of Birth:	Social Security Number: - -	
Home Address: Street (no post office box)		City	State	Zip
Relationship to Patient: (circle one) Spouse/Parent/Legal Guardian/Legal Representative				
Employer Name:		Occupation	Employer Phone: ( ) -	
Employer Address: Street (no post office box please)		City	Stat	Zip
FIRST INSURANCE		**Referral Required:** ____ Yes	____ No	
Insurance Name:			Insurance Phone: ( ) -	
Insurance Address: Street		City	State	Zip
Policy Holder's Name:		Date of Birth:	Social Security Number: - -	
Policy ID Number:		Policy Group Number:	Policy Effective Date:	
SECOND INSURANCE		**Referral Required:** ____ Yes	____ No	
Insurance Name:			Insurance Phone: ( ) -	
Insurance Address: Street		City	State	Zip
Policy Holder's Name:		Date of Birth:	Social Security Number: - -	
Policy ID Number:		Policy Group Number:	Policy Effective Date:	
THIRD INSURANCE		**Referral Required:** ____ Yes	____ No	
Insurance Name:			Insurance Phone: ( ) -	
Insurance Address: Street		City	State	Zip
Policy Holder's Name:		Date of Birth:	Social Security Number: - -	
Policy ID Number:		Policy Group Number:	Policy Effective Date:	
EMERGENCY CONTACT				
Name:	Telephone:		Relationship:	

Is your visit due to a job related accident? □ Yes □ No If yes, indicate the date of injury: ____/____/____

Please be sure to complete your employer information at the top of the page.

Would you be interested in having communications sent to you via your e-mail address?
Examples: appointment reminders, administrative updates and health bulletins? ______ Yes ______ No

How did you hear about our Practice? (circle one)
Relative/Friend/Telephone Book/Web Site/Physician Referral/Other

Regional Eye Associates, Inc

Family Physician ____________________ **Previous Eye Doctor** _________________

Past Medical History: (Surgeries/Illnesses/Medications/Allergies)

- **Surgeries:**

- **Illnesses/Hospitalizations:**

- **Medications (please list the dosage if you know it)**

- **Allergies (Please check the list below and write in any other allergies that you migh have.**

	Y	N		Y	N		Y	N	Notations
Latex			Cipro (Fluoroquinolone)			Betadine/Iodine			
Tape			Genatmicin/Tobramycin			Seafood			
Penicillin			Keflex/Cephalosporin			Egg White			
Vancomycin			Anesthesia medications			Soybeans			
Other, including eye drops:									

Patient ________________________________ DOB ____________________

Date of update										
Tech										
Doctor										

Regional Eye Associates, Inc

Social History:

Lives with		Alcohol		Smoking	
Occupation		Drug Dependence		Vitamins	
Occupation History			Mobility		
Activities	❒ computer ❒ TV ❒ Driving ❒ Reading ❒ crafts/sewing ❒ Music ❒ hunting ❒ fishing ❒ skiing ❒ boating ❒ jogging ❒ exercising				
Other					

Family History:

Condition	Y	N	Who	Condition	Y	N	Who	Condition	Y	N	Who
Glaucoma				Crossed Eyes				Hypertension			
Cataract				Blindness				Tuberculosis			
Retinal Detachment								Stroke			
Degeneration				Diabetes				Anesthesia			

Review of Systems: **Do you have any of the following problems? Check N for major gro (bolded) if there are no problems for that organ system or question and go to the next category.**

	Y	N		Y	N		Y	N
Constitutional			**Genital - Urinary**			**Hematologic/lymphatic**		
Weight loss, fever, fatigue			Kidney failure/Dialysis			Anemia		
Head/Neck/Nose/Throat			Incontinence/Urgency			Blood thinners/bruise		
Sinus			Pregnancy			Coumadin		
Teeth			Prostate problems			ASA		
Throat problems			**Musculoskeletal**			Plavix		
Hearing impaired/Aids			Arthritis			Blood clots		
Pulmonary Disease			Mobility problems					
Coughing/Wheezing			Neck Problems			**Cancer**		
Asthma/Bronchitis			Extremity problem			Type of cancer?		
Oxygen dependent			Prosthesis					
Sleep apnea			**Skin**			**Allergic/Immunologic**		
Shortness of Breath			Eczema/Psorias			Autoimmune disease?		
Cardiac/Vascular			Rashes					
Congestive Heart Failure			Ulcers			**Specific meds ever used?**		
Chest pain			**Neurologic**			Flomax (Tamsulosin)		
Palpitations/Irreg. beat			Vertigo; Dizziness			Uroxatral		
High Blood Pressure			Weak; Faint			Hytrin (Terazosin)		
High cholesterol			Seizures			Cardura (Doxazosin)		
Pace Maker/Defib			History Stroke/paralysis			**Anesthesia history**		
Shortness of Breath			Parkinsons			Problems in past?		
Exercise Intolerance			**Psych**			Family problems?		
Murmur			Claustrophobia			**Infections**		
Valve disease			Altzheimers/Dementia			Hepatitis		
Gastrointestinal			Depression			MRSA (Staph infection)		
Ulcers, Reflux, Nausea,			Panic Attacks			Tuberculosis		
Diarrhea, hiatal			**Endocrine**			HIV		
Problems swallowing			Diabetes			Other		
Liver/Cirrhosis/Jaundice			Thyroid					
Other or explanations:								

Patient ______________________ DOB ______________

Date of update										
Tech										
Doctor										