# Patient Registration Form

Name: _____ Today's Date: _____
Last First MI

Address: _____
Street City State Zip

Phone: _____ _____ _____
Best # Daytime # Cell #

Date of Birth: _____ ❒ Male ❒ Female Occupation: _____

Employer: _____

Social Security #: _____ Email: _____

Spouse's Name: _____ Spouse's Date of Birth: _____

Emergency Contact Name: _____ Best #: _____

Name of Family Doctor or Primary Care Physician: _____

Address: _____ Phone: _____

How Did You Hear About Us? ❒ Website ❒ Yellow Pages ❒ Insurance
❒ Family/Friend: _____ ❒ Other: _____

Were You Referred By Another Doctor? ❒ Yes ❒ No If Yes, Name of Doctor: _____

Address: _____ Phone: _____

**Health Insurance Information:**

Do You Have Health Insurance? ❒ Yes ❒ No Do You Have Medicare? ❒ Yes ❒ No

Do You Have Vision Insurance? ❒ Yes ❒ No ID#: _____

If Other Than Yourself, Who is the Subscriber of the Insurance: _____

Subscriber's Date of Birth: _____

Do You Have Secondary Health Insurance? ❒ Yes ❒ No

***If you have an HMO or any insurance that requires a referral, contact your family doctor for this. We MUST have a referral BEFORE you see the doctor or payment will be due the day of your visit.***

SCHEIN ERNST MISHRA EYE

# Health History Form

**PMFSH + ROS Updated (Office Staff Only):**

| Date | Initials | Date | Initials |
|---|---|---|---|
| _____ | | _____ | |
| _____ | | _____ | |
| _____ | | _____ | |

(Please do not write above this line)

Name: _____ Today's Date: _____

Date of Birth: _____ ❒ Male ❒ Female Race: _____ Email: _____

Family Physician: _____ Phone: _____

**Past Medical History**

**Have you ever received a pneumonia vaccination?**

❒ Yes ❒ No

**Do you know if you ever had:**

Diabetes: ❒ Yes ❒ No Insulin: ❒ Yes ❒ No

High Blood Pressure: ❒ Yes ❒ No

Heart Disease: ❒ Yes ❒ No

High Cholesterol: ❒ Yes ❒ No

**Please Specify the Following:**

Blood Disorders: _____

Stomach or Digestive Disorders: _____

Neurologic Disorders (ex. Alzheimer's, Multiple Sclerosis, Stroke, Parkinson's): _____

Psycological Disorders (ex. Anxiety, Depression):

_____

Lung Disorders (ex. Asthma, Emphysema/COPD):

_____

Thyroid Disorders: _____

Arthritis / Joint Disorders: _____

Liver, Kidney, Prostate Disorders: _____

Other: _____

**Eye History:**

| | | |
|---|---|---|
| Contact Lenses | ❒ Yes | ❒ No |
| Eyeglasses | ❒ Yes | ❒ No |
| Lazy Eye | ❒ Yes | ❒ No |
| Glaucoma | ❒ Yes | ❒ No |
| Cataracts | ❒ Yes | ❒ No |
| Retinal Detachment/Tear | ❒ Yes | ❒ No |
| Eye Injury | ❒ Yes | ❒ No |
| Eye Surgery | ❒ Yes | ❒ No |

| **Family History (Blood Relatives):** | | **Relation** |
|---|---|---|
| Glaucoma/ High Eye Pressure | ❒ | _____ |
| Retinal Detachment | ❒ | _____ |
| Macular Degeneration | ❒ | _____ |
| Cataracts | ❒ | _____ |
| Diabetes | ❒ | _____ |
| Blindness | ❒ | _____ |

Heart Disease/Stroke ❒ _____

**List All Current Medications Including Eyedrops:**

Medication / Dosage / Quantity / Times per Day

_____ / _____ / _____ / _____
_____ / _____ / _____ / _____
_____ / _____ / _____ / _____
_____ / _____ / _____ / _____
_____ / _____ / _____ / _____
_____ / _____ / _____ / _____
_____ / _____ / _____ / _____

**List All Surgeries:**

_____
_____
_____
_____

**List All Previous Hospitalizations:**

_____
_____
_____
_____

**List All Allergies Including to Medications:**

_____
_____
_____
_____

**Social History:**

Alcohol: ❒ Yes ❒ No Frequency: _____

Tobacco: ❒ Yes ❒ No Frequency: _____

**Dependency Status:**

❒ Single ❒ Married ❒ Widowed ❒ Divorced

**Children #:** _____

## Health History Form (Continued)

***Please Check Yes Or No To All Items**

| | | Explanation: |
|---|---|---|
| **Eyes:** | | |
| Blurred Vision | ❒ Yes ❒ No | _____ |
| Double Vision | ❒ Yes ❒ No | _____ |
| Pain | ❒ Yes ❒ No | _____ |
| Discharge/Crusting | ❒ Yes ❒ No | _____ |
| Redness | ❒ Yes ❒ No | _____ |
| Itching | ❒ Yes ❒ No | _____ |
| Light sensitivity | ❒ Yes ❒ No | _____ |
| Other | ❒ Yes ❒ No | _____ |
| **Ears, Nose, Mouth Throat:** | | |
| Pain | ❒ Yes ❒ No | _____ |
| Mass | ❒ Yes ❒ No | _____ |
| Discharge | ❒ Yes ❒ No | _____ |
| Hearing Loss | ❒ Yes ❒ No | _____ |
| Smell | ❒ Yes ❒ No | _____ |
| Other | ❒ Yes ❒ No | _____ |
| **Cardiovascular:** | | |
| Chest Pain | ❒ Yes ❒ No | _____ |
| Shortness of Breath on Exertion | ❒ Yes ❒ No | _____ |
| Irregular Heart Beat | ❒ Yes ❒ No | _____ |
| Other | ❒ Yes ❒ No | _____ |
| **Respiratory:** | | |
| Short if breath | ❒ Yes ❒ No | _____ |
| Cough | ❒ Yes ❒ No | _____ |
| Asthma | ❒ Yes ❒ No | _____ |
| Other | ❒ Yes ❒ No | _____ |
| **Gastrointestinal:** | | |
| Bowel habits/change | ❒ Yes ❒ No | _____ |
| Diarrhea | ❒ Yes ❒ No | _____ |
| Constipation | ❒ Yes ❒ No | _____ |
| Stomach Pain | ❒ Yes ❒ No | _____ |
| Ulcers | ❒ Yes ❒ No | _____ |
| Other | ❒ Yes ❒ No | _____ |
| **Hemotologic/Lymphatic:** | | |
| Anemia | ❒ Yes ❒ No | _____ |
| Blood Disease | ❒ Yes ❒ No | _____ |
| Bleeding disorder | ❒ Yes ❒ No | _____ |
| Swollen lymph nodes | ❒ Yes ❒ No | _____ |
| Other | ❒ Yes ❒ No | _____ |
| **Musculoskeletal:** | | |
| Weakness | ❒ Yes ❒ No | _____ |
| Joint pain | ❒ Yes ❒ No | _____ |
| Decreased range of motion | ❒ Yes ❒ No | _____ |
| Other | ❒ Yes ❒ No | _____ |
| **Skin/Breast:** | | |
| Masses | ❒ Yes ❒ No | _____ |
| Tumors | ❒ Yes ❒ No | _____ |
| Pigmented lesions | ❒ Yes ❒ No | _____ |
| Rash | ❒ Yes ❒ No | _____ |
| Other | ❒ Yes ❒ No | _____ |
| **Neurologic:** | | |
| Weakness | ❒ Yes ❒ No | _____ |
| Tingling | ❒ Yes ❒ No | _____ |
| Numbness | ❒ Yes ❒ No | _____ |
| Other | | |
| **Have you ever experienced unexplained:** | | |
| Fever | ❒ Yes ❒ No | _____ |
| Weight loss | ❒ Yes ❒ No | _____ |
| Other | ❒ Yes ❒ No | _____ |

# Patient Financial Policy

Thank you for choosing **Schein Ernst Mishra Eye** as your eye care provider. We are committed to provide each of our patients with quality health care in a way that is financially responsible for both our patients and our practice. Your clear understanding of our Financial Policy is important to our professional relationship.

**Consent for Treatment**
By signing this form, I consent to and authorize my eye care provider to treat me. I understand that my provider is available to explain the treatment and I have the right to refuse treatment.

**Insurance Billing**
We participate in most major health insurance plans as well as many vision plans. As a courtesy to our patients, we will submit insurance claims to your carrier; however, we expect you to:

- Be responsible for understanding the details of your insurance coverage requirements, including routine vs. medical coverage for eye exams, pre-authorization for procedures, and annual deductible and copay/coinsurance amounts.
- Provide us with a current copy of your insurance card and notify us of any changes in your insurance coverage. If we do not have current insurance billing information, we will expect full payment at the time of service.
- **Pay your copay/coinsurance/deductible at the time of service.**

**Assignment of Insurance Benefits**
I authorize the release of any medical information necessary to process insurance claims for surgical and/or medical services provided to me or my dependents by **Schein Ernst Mishra Eye**. I also authorize payment of benefits directly to **Schein Ernst Mishra Eye** for services provided to me or my dependents. I understand that this authorization may not result in full payment by my insurance carrier for the charges incurred and I agree that I am financially responsible to make payment in full on remaining patient balances should my insurance carrier determine the services I received are not covered.

**No insurance**
Patients without insurance, and only those patients without insurance, currently receive a **50%** discount off of our regular fees**. Payment for services rendered is due on the day of service unless other arrangements have been made.** This discount applies to all services rendered by our physicians only. It does not apply to any other provider of services, drug fees, or elective services such as LASIK, Lid surgery, or Botox. Patients with insurance already receive discounted rates through their insurance carrier and are not eligible to receive this discount.

**Non-covered services**
Please be aware that some of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. An example is Refraction, which is a test required to measure visual acuity and to prescribe lenses. Although an important part of your eye exam, it is excluded from Medicare and many medical insurance plans. We are required to charge your refraction fee separately from your exam**. Payment for these services must be paid at the time of your visit.**

**Minors**
The parent(s) or guardian(s) accompanying a minor are responsible for providing current insurance information for the minor and/or payment in full for services provided. Unaccompanied minors must have an authorization for medical treatment signed by a parent or guardian and is responsible for providing current insurance information for self and/or payment in full for services provided.

**Missed Appointments**
We would appreciate your help and the courtesy of a phone call if you are unable to keep your appointment. At **Schein Ernst Mishra Eye** we work hard to meet the busy schedules of our patients when scheduling their appointments. Your appointment time has been set aside for you. This time is unavailable to other patients. Therefore, we require **48 hours advance notice** if you need to cancel or reschedule your appointment. If you cancel or reschedule late for consecutive appointments or fail to notify us for consecutive appointments, we will no longer be able to schedule an appointment in one of our offices. Appointment reminders calls or texts will be sent as a courtesy.

**Patient's Right to Privacy**
In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we have our Notice of Privacy Practices on display in the reception area and copies available at the front desk upon request. This document describes in detail how information about you, the patients, can be used within our office and with others who need to know the reason for treatment, payment, and/or health care operations.

**Returned Checks**
A $40 fee will be assessed to your account for each returned check. This fee and the original check amount must be paid in full with cash, credit card, or money order prior to your next appointment. After receiving two (2) returned checks, we will no longer accept checks as a method of payment.

By signing below, I attest I have read the above and authorize **Schein Ernst Mishra Eye** to treat, bill, and share my medical information as discussed above.

**Signature of Patient / Parent or Guardian (if minor)**

X _____ Date: _____

Patient or Guardian (if minor) Printed Name: _____

Relationship to Patient: _____ (for minor)


# Refraction Information Sheet

Effective for all refractions done from
January 1, 2018 – December 31, 2018

Refraction is the measuring of the current "refractive-error" (checking your nearsightedness, farsightedness and astigmatism). The doctor will do the refraction only when indicated. Refraction is a necessary part of a work up for many reasons including blurred vision, eye strain, cataract, and YAG evaluation. Also, refraction is necessary every couple of years so that we have an updated prescription on file for you when, and if, you should need it.

Most medical insurance companies, including **Medicare**, do not cover the refraction charge. They require that we charge it as a separate charge item, apart from the medical exam. If you have vision insurance, your insurance may cover this refraction. Insurance companies require we obtain your signature as verification that you are aware of the billing policies. The fee for refractions is **$35.00**, and will be due at time of service.

This is an acknowledgement of a service that may or may not be performed during your evaluation. You are able to decline the refraction if you wish. A technician will inform you of the refraction before it is performed.

Printed Name: _____

I have read and understand the policy as written above. I acknowledge that if, in the case of a medical diagnosis, my insurance may not cover the refraction and agree to pay the fee of $35.00.

Signature: _____ Date: _____

Patients Account Number: _____ (for office use)

# Authorization for Disclosure of PHI to Family/Friends

**This form is optional**. Please print information if you would like to include someone in your care. Sign and Date at bottom.

Patient Name: _____

SEME Account #: _____ Date of Birth: _____

Entity Requested to Release Information: _____

Purpose of request (who will be authorized to receive information) - I authorize the entity identified above to disclose or provide protected health information, about me to the individual/entity listed below.

Who will be authorized to receive information (the individual/entity whom is to receive your PHI):

_____
Name of Person Authorized & Date of Birth Relationship

_____
Name of Person Authorized & Date of Birth Relationship

_____
Name of Person Authorized & Date of Birth Relationship

* **Secure Communication** - Note that regular email is not secure, and it is possible for your PHI to be compromised during transmission from our practice. Do not designate email as your preferred method of disclosure if this is of concern to you.

Description of information to be disclosed - I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

Entire patient record; **or**, check **only** those items of the record to be disclosed:

□ **All Medical Records**

□ Lab results, pathology reports □ Eyeglass Prescriptions

□ Visual Testing □ Contact Lens Prescriptions

Purpose of disclosure (please record the purpose of the disclosure or check patient request):

□ Patient Request □ other (please specify): _____

- This authorization will expire at the end of the calendar year, unless you specify an earlier termination. You must submit a new authorization form after the expiration date to continue the authorization. Please list the date of expiration if earlier than the end of the calendar year: _____
- You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
- We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

_____ _____
Patient or authorized representative signature date

You have the right to receive a copy of signed authorizations upon request.