BAYBROOK MODERN EYECARE
REGISTRATION FORM

Today's Date:

PATIENT INFORMATION

Last Name:	First Name:	Middle Initial:	Title: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed			

Address:	Apt./Suite:	Birth Date:	Age:	Sex: ☐ M ☐ F
City:	State:	Zip Code:	SSN:	
Email:	Home Phone:	Cell Phone:		
Employer:	Occupation:	Work Phone:		
Referred By: ☐ Physician/Doctor ☐ Insurance ☐ Family ☐ Friend ☐ Co-worker ☐ Walk-in ☐ Website ☐ Social Media				

VISION INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Insurance Name: ☐ EyeMed ☐ Humana VCP ☐ VSP ☐ Superior Vision ☐ Other:			
Primary Insured Name:		Member ID #:	
Primary Insured SSN:	Birth date:	Group #:	
Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other		Employer:	
Address (if different):	City:	State:	Zip Code:

MEDICAL INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Insurance Name: ☐ Aetna ☐ BCBS ☐ UHC ☐ Cigna ☐ Humana ☐ Medicare ☐ Medicaid ☐ Other:			
Primary Insured Name:		Member ID #:	
Primary Insured SSN:	Birth date:	Group #:	
Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other		Employer:	
Address (if different):	City:	State:	Zip Code:

IN CASE OF EMERGENCY

Contact Name:	Relationship to patient:
Home Phone:	Work Phone:

APPOINTMENT RECALL

As a courtesy, our office will pre-appoint you for your next eye exam to serve as a yearly reminder. Would you like us to make an appointment for your eye exam next year now? ☐ Yes ☐ No

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize BAYBROOK MODERN EYECARE or insurance company to release any information required to process my claims.

Patient/Guardian signature:	Date:

PATIENT HISTORY

GENERAL INTAKE INFORMATION

Reason for visit: ☐ Glasses ☐ Contacts ☐ Medical eye problem ☐ Interested in LASIK

Last Eye Exam:	Previous Eye Doctor:

EYE CONCERNS/SYMPTOMS: (PLEASE CHECK ANY THAT APPLY)

☐ Blurred distance vision	☐ Floaters/Spots	☐ Amblyopia (lazy eye)	☐ Watery eye(s)
☐ Blurred near vision	☐ Flashes	☐ Strabismus (eye turn/crossed eye)	☐ Foreign body sensation
☐ Distorted vision	☐ Halos/Glare	☐ Infection of eye(s)	☐ Sandy/Gritty feeling
☐ Double vision	☐ Light sensitivity	☐ Burning	☐ Eye pain/Soreness
☐ Fluctuating vision	☐ Tired eyes	☐ Itching	☐ Dryness
☐ Loss of central vision	☐ Drooping eyelid(s)	☐ Redness	☐ Stye(s)
☐ Loss of peripheral vision	☐ Headaches	☐ Mucous discharge	☐ Other:

EYE CONDITIONS: (PLEASE CHECK ANY THAT APPLY)

Y	N	Family		Y	N	Family		Y	N	Family	
☐	☐	☐	Cataract	☐	☐	☐	Retinal Detachment	☐	☐	☐	Color Blindness
☐	☐	☐	Glaucoma	☐	☐	☐	Eye Surgery	☐	☐	☐	Lazy Eye
☐	☐	☐	Macular Degeneration	☐	☐	☐	Eye Injury/Trauma	☐	☐	☐	Keratoconus
☐	☐	☐	Diabetic Retinopathy	☐	☐	☐	Blindness	☐	☐	☐	Eye Allergies

GLASSES HISTORY

Y	N		What type of glasses do you wear? (Check any that apply)		
☐	☐	Do you currently wear glasses?	☐ Single vision distance	☐ Progressives (no line)	☐ Sport glasses
☐	☐	Do you have problems with night vision?	☐ Single vision near	☐ Computer glasses	☐ Back-up glasses
☐	☐	Do you have glare problems?	☐ Bifocals (lined)	☐ Safety glasses	☐ Over the counter/Non-Rx
☐	☐	Are your glasses damaged or lost?	☐ Trifocals (lined)	☐ Sunglasses	

COMPUTER VISION DEMAND

How many hours per day do you use a computer, laptop and/or mobile device? ☐ Not at all ☐ Less than 4 hrs/day ☐ More than 4 hrs/day

Do you have unusual ergonomic demands? ☐ Yes ☐ No	Do you view the computer and paperwork simultaneously? ☐ Yes ☐ No
Do you use multiple desktop monitors? ☐ Yes ☐ No	Do wear contacts while using the computer? ☐ Yes ☐ No

CONTACT LENS HISTORY

If not a contact lens wearer, are you interested in contact lens wear? ☐ Yes ☐ No	Have you ever worn contacts? ☐ Yes ☐ No
What brand of contacts do you wear?	How old are your current contacts?
How often do you replace your contacts?	How many hours per day do you wear your contacts?
Do you sleep in your contacts? ☐ Yes ☐ No	What solution do you use to clean and disinfect your contacts?

Please check any that apply:

☐ I want contacts for special occasions/sports/hobby	☐ I have problems with my current contacts	☐ I have no issues with my current contacts
☐ I want contacts to change my eye color	☐ I experience dryness with my contacts	☐ I am out of my contact lens supply

SOCIAL HISTORY

Do you smoke? ☐ Yes ☐ No	Type/amount/duration:	Do you use illegal drugs? ☐ Yes ☐ No	Type/amount/duration:
Do you drink alcohol? ☐ Yes ☐ No	Type/amount/duration:		

MEDICAL HISTORY

Primary Care Physician:		Last Physical Exam:	
Medications:		Supplements/Vitamins:	
Drug Allergies:	Reaction:	Allergies:	Reaction:

MEDICAL HISTORY

REVIEW OF SYSTEMS

Please check if you are having problems in any of the following areas as many of these conditions have eye-related manifestations:

CONSTITUTIONAL

Self	Family	
☐	☐	Cancer
☐	☐	Fatigue
☐	☐	Fever Syndrome
☐	☐	Developmental Disabilities

ENT

Self	Family	
☐	☐	Hearing loss
☐	☐	Sinusitis
☐	☐	Dry mouth
☐	☐	Laryngitis

NEUROLOGICAL

Self	Family	
☐	☐	Multiple Sclerosis
☐	☐	Epilepsy
☐	☐	Cerebral Palsy
☐	☐	Tumor
☐	☐	Stroke/CVA
☐	☐	Migraine/Headache
☐	☐	Autism

PSYCHIATRIC

Self	Family	
☐	☐	Depression
☐	☐	Attention Deficit
☐	☐	Anxiety Disorder
☐	☐	Bipolar Disorder

CARDIOVASCULAR

Self	Family	
☐	☐	Hypertension
☐	☐	Stroke/CVA
☐	☐	Heart Disease
☐	☐	Vascular Disease
☐	☐	Congestive Heart Failure

RESPIRATORY

Self	Family	
☐	☐	Cigarette Smoker
☐	☐	Asthma
☐	☐	Bronchitis
☐	☐	Emphysema
☐	☐	Chronic Obstruction
☐	☐	Sleep Apnea

GASTROINTESTINAL

Self	Family	
☐	☐	Crohn's
☐	☐	Colitis
☐	☐	Ulcer
☐	☐	Acid Reflux
☐	☐	Celiac Disease

GENITOURINARY

Self	Family	
☐	☐	Kidney Disease
☐	☐	Prostate Disease/Cancer
☐	☐	STD
☐	☐	Benign Prostate Hypertrophy
☐	☐	Pregnant
☐	☐	Nursing

MUSCULOSKELETAL

Self	Family	
☐	☐	Arthritis
☐	☐	Osteoarthritis
☐	☐	Fibromyalgia
☐	☐	Muscular Dystrophy
☐	☐	Ankylosing Spondylitis
☐	☐	Osteoporosis
☐	☐	Gout

INTEGUMENTARY

Self	Family	
☐	☐	Eczema
☐	☐	Rosacea
☐	☐	Psoriasis
☐	☐	Herpes Simplex/Cold Sores
☐	☐	Herpes Zoster/Shingles

ENDOCRINE

Self	Family	
☐	☐	Type 2 Diabetes Mellitus
☐	☐	Type 1 Diabetes Mellitus
☐	☐	Thyroid Dysfunction
☐	☐	Hormonal Dysfunction

HEMATOLOGIC/LYMPHATIC

Self	Family	
☐	☐	Anemia
☐	☐	Larger-Volume Blood Loss
☐	☐	Ulcer
☐	☐	Hypercholesteremia

ALLERGIC/IMMUNE

Self	Family	
☐	☐	Drug Allergies
☐	☐	Environmental Allergies
☐	☐	Rheumatoid Arthritis
☐	☐	Lupus
☐	☐	Sjogren's Syndrome
☐	☐	HIV
☐	☐	AIDS

Please list any other conditions not listed above:

ADDITIONAL TESTING

Our goal is to set the standard in professional, quality eye care. We are committed to prevention of eye disease as well as early detection. The following tests are available at our office to help identify changes at early stages in conditions such as retinal holes, tears, detachments, macular degeneration, tumors, cataracts and glaucoma as well as other retinal and optic nerve diseases and abnormalities.

RETINAL PHOTOS/OPTOMAP

This unique technology captures a digital retinal image of about 80% of the retina in a panoramic view compared to a 15% retinal view with traditional imaging methods. This technology allows our doctors to examine your retina with NO DROPS and NO SIDE EFECTS. Other benefits of an OPTOMAP include:

- Early detection of life threatening diseases like cancer, stroke and cardiovascular disease.
- Helps our doctors detect early signs of retinal disease more efficiently and effectively than traditional eye exams.
- Your retinal image is saved for future references.
- No adverse health effects: NO DROPS and NO SIDE EFFECTS.
- Fast, painless and comfortable.

I agree to the OPTOMAP ($39): ☐ Yes ☐ No ☐ No, I prefer to dilate my eyes today. ☐ Not sure, I want to discuss with the doctor.

PUPIL DILATION

Dilation is highly recommended yearly if:

- It's your first eye exam or first visit at our office.
- You are diabetic.
- You are over the age of 45.
- You have glasses or contact lens prescriptions over -4.00.
- You have a previous diagnosis or family history of conditions such as: glaucoma, macular degeneration, retinal defects, retinopathy and cataracts.
- You are experiencing floaters and/or flashes of light.
- You are experiencing headaches/migraines.
- You have not been dilated in two years.

Please note:

- The side effects you may experience with dilation include light sensitivity that may last 4-6 hours and blurred near vision that lasts for approximately 2-3 hours. Also, the risk of elevated eye pressure may be induced, however rare. Symptoms induced by elevated eye pressures may include ocular redness and sharp pain. If you experience such symptoms, contact the doctor immediately.

I agree to the Pupil Dilation ($25): ☐ Yes ☐ No ☐ No, I prefer to have the OPTOMAP taken today. ☐ Not sure, I want to discuss with the doctor.

AUTOMATED VISUAL FIELD SCREENING

This technology aids in the early detection of glaucoma changes, retinal detachments, macular degeneration, cataracts, retinal and neurological diseases such as tumors and optic nerves diseases. It is highly recommended if:

- You have previous history or family history of stroke, vision loss or glaucoma.
- You have new, unusual or persistent headaches/migraines.
- You experience flashes and/or floaters.
- Your eye pressures are over 25mmHg in either eye or difference between each eye is more than 3mmHg (our technician will check this).

I agree to the Visual Field Screening ($20): ☐ Yes ☐ No ☐ Not sure, I want to discuss with the doctor.

LIABILITY RELEASE

I have been informed by the staff and optometrists at Baybrook Modern Eyecare (from the above and/or verbal explanations) of the importance of a visual field screening, pupil dilation and/or OPTOMAP. If I have chosen not to have one or both tests performed, or any other recommended test or referral, or I have given incomplete or inaccurate information; I will not hold the optometrists and/or staff at Baybrook Modern Eyecare responsible for any diseases or pathology that goes undetected due to the lack of diagnostic information that could have been obtained by these testing procedures.

I understand if I decline the visual field test, pupil dilation and retinal photos (OPTOMAP) against my optometrist's recommendation, I absolve my optometrist at Baybrook Modern Eyecare of any responsibility or liability for undiagnosed conditions.

PATIENT NAME (PRINT): _____

PATIENT (or guardian) SIGNATURE: _____

DATE: _____

FINANCIAL AGREEMENT/ASSIGNMENT OF BENEFITS

FINANCIAL AGREEMENT

I agree that in return for the services provided to me by Baybrook Modern Eyecare, I will pay my account at the time service is rendered. If my account is sent to an agency for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance are hereby assigned to Baybrook Modern Eyecare. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Baybrook Modern Eyecare. However, I understand that I am primarily responsible for the payment of my bill.

☐ **Yes, I acknowledge that I have read and understand these terms and agree to the terms of the Financial Agreement:**

PATIENT NAME (PRINT): _____

PATIENT (or Guardian) SIGNATURE: _____

DATE: _____

ASSIGNMENT OF BENEFITS

MEDICARE: I request that payment of authorized Medicare benefits be made on my behalf to Baybrook Modern Eyecare for services furnished me by Doctor(s). I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or 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 is indicated in the item 9 of the CMS 1500 form, my signature authorizes releasing the information to the insurer or agency shown. Baybrook Modern Eyecare accepts the charge determination of the Medicare carrier as the full charge and I am responsible for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

MEDIGAP: I understand that if a MediGap policy or other health insurance is indicated in item 9 of the HCFA-1500 form, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to Baybrook Modern Eyecare, if possible or otherwise to me.

OTHER INSURANCE: I authorize payment of my medical insurance benefits to Baybrook Modern Eyecare. I understand I am financially responsible for any charges whether or not paid by said insurance. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Baybrook Modern Eyecare. I authorize Baybrook Modern Eyecare to release any information required to process any and all claims for reimbursement on my behalf. A copy of this authorization may be used in place of the original.

NON-COVERED SERVICES: I understand that Baybrook Modern Eyecare's contract with health care service plans and vision plans relates only to items and services which are "covered" by the health care service plans and vision plans. Accordingly, I accept full financial responsibility for all items or services, which are determined by the health care service plans and vision plans not to be covered, including the refraction fee. I agree to cooperate with Baybrook Modern Eyecare to obtain necessary health care service plan and vision plan authorizations.

☐ **Yes, I acknowledge that I have read and understand these terms and agree to the terms of the Assignment of Benefits:**

PATIENT NAME (PRINT): _____

PATIENT (or Guardian) SIGNATURE: _____

DATE: _____

HIPAA NOTICE OF PRIVACY PRACTICES

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please read it carefully. The privacy of your health information is important to us.

Our Legal Duty: We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties and your rights concerning your health information. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We will use and communicate your health information only for the purpose of providing your treatment, obtaining payments and conducting health care operations.

USES AND DISCLOSURES OF HEALTHCARE INFORMATION:

To Provide Treatment: We will use and disclose your health information within our office to provide you with the best health care possible. This may include business office staff, assistants, opticians, physician assistants, nurses, and physicians. In addition, we may share our health information with referring physicians, laboratories, pharmacies, and other health care personnel providing you treatment, including contact lens and frame companies.

To Obtain Payment: We may use and disclose your health information to obtain payment for services, materials, and treatment you received in our office. We may do this with insurance forms filed for you by mail or send electronically.

Healthcare Operations: Your health information may be used during performance evaluation of our staff, training programs for students, interns, associates, and business and/or clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine process of certification, licensing or credentialing activities.

Appointment Reminders: Because we believe regular care is very important to your general health, we will remind you of a scheduled appointment or that it is time to contact us for an appointment. Additionally, we may contact you for follow up on your care and inform you of treatment options or services that may interest you or a family member. These may include postcards, folding cards, letters, telephone, voice mail, or email.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we believe a patient is a victim of abuse, neglect or domestic violence, or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

Public Health and National Security: We may disclose to Federal Officials or military authorities your health information required for lawful intelligence, counterintelligence, and other national security activities.

Law Enforcement: As permitted or required by State or Federal Law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

Family, Friends, and Caregivers: We may disclose your health information to a family member, friends, care giver, or other person who you tell us will be helping you with your home hygiene, treatment, medications, or payment. In case of an emergency, where you are unable to tell us what you want we will use our very professional judgment when sharing your health information. We will also use professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, materials, or other similar forms of health information.

To Coroners, Funeral Directors, and Medical Examiners: We may be required by law to provide information about your health to coroners, funeral directors, and medical examiners for the purpose of determining a cause of death and preparing for a funeral.

Required by Law: We may use or disclose your health information when required to do so by law.

Your Authorization: Other than stated above or where Federal, State or Local Law requires us, we will not disclose your health information without your written authorization. You may revoke your authorization in writing at any time. Your revocation will not affect any use of disclosures permitted by your authorization while it was in effect.

PATIENT RIGHTS:

Access: You have the right to look or get copies of your health information, with limited exceptions (you must make a request in writing to obtain access to your health information). If you request copies, we will charge you a fee for each page, and per hour for staff time to locate, duplicate and assemble your copy, and postage if you request the copies to be mailed to you.

Documentation of Health Information: You have the right to ask us for a description of how and where your health information was used by our office for any reason other than for treatment, payment or health care operations and certain other activities. Our documentation procedures will enable us to provide information from April 14, 2002 and forward. Please let us know in writing the time period for which you are interested. Your request must be limited to no more than six years at a time. We may charge you a reasonable fee for your request.

Alternative Communications: You have the right to request that we communicate with you about your health information by alternative means or to alternative location. (You must make your request in writing). Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location. We will make every effort to honor your reasonable request for confidential communications.

Amendments: You have the right to ask us to amend your health information. In order to standardize our process, please submit your request in writing and describe the reason for the change. Your request may be denied under certain circumstances.

Request a Paper Copy of this Notice: You have the right to obtain a copy of this Notice of Privacy Practices from our office at any time.

Complaints: If you think that we have not properly respected the Privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office of Civil Rights, 110 West 49th Street, Austin, Texas, 78756. We support your right to the privacy of your health information. If you want more information please contact our office.

☐ **Yes, I acknowledge that I have received and/or read a copy of the Notice of Privacy Practices issued by Baybrook Modern Eyecare. I agree to allow electronic communication as defined in security practices effective April 21, 2005.**

PATIENT NAME (PRINT): _____

PATIENT (or GUARDIAN) SIGNATURE: _____

DATE: _____