

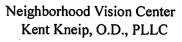


# Welcome! Please fill out completely

PATIENT REGISTRAT	ION:				
Name: First Midd	le lact	Date of Birth:	Age: _	Today's Date:	
Address:					
Home Phone:	Work Phone:	Cell Phone:		E-Mail:	
Sex: □ Male □ Female	How would you prefer to	be contacted?   Home	□ Work □	Cell	
Patient's Social Security #:	If:	student, grade:	_ School:	<del></del>	
Occupation:	E	Employer:			
Marital Status:	Spouse or Em	ergency contact name:			
Primary Care Physician:			Las	st Medical Exam:	
If the patient is a child, Parer	nt / Guardian name:		Las	st eye exam:	
For new patients: How did	you hear about us?				
□ Friend / Acquaintance □	Insurance Plan   Drivi	ng by □ Phone book □ :	Internet 🗆 Oth	er	
If referred by a friend or fam	ily member, who:				1.00
VISION INSURANCE:					****
Who is the primary insured p	erson on the vision insura	nce plan?: □ Self (the pati	ient) ⊓ Spouse	of the natient - Pare	ent of the nations
Insured's name (if other than Insurance company: Insurance company's address Insured's member ID #:	the patient):	Insured's D Insured's er Insured's Se	ate of Birth (if o mployer: oc. Sec. # (if oth	ther than the patient):	
PRIMARY MEDICAL I	NSURANCE:				
Who is the primary insured p Insured's name (if other than Insurance company: Insurance company's address	the patient):	Insured's D	ate of Birth (if o	of the patient	<u> </u>
Insured's member ID #:		Insured's gr			***

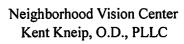
#### **SECONDARY MEDICAL INSURANCE:**

□ If there is also a secondary Medical Insurance, please check here and notify the receptionist





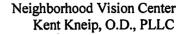
PERSONAL EYE HISTORY						
Chief complaint / Reason	n(s) for visit:					
Current problems with y	our eyes (Check all that app	oly):				
□ Blurred vision □ Flashes □ Dryness □ Itching □ Tearing	n □ Eyestrain or tired eyes □ Double vision □ Burning □ Redness	□ Loss of vision o □ Infection of the eye or lic □ Foreign body sensation □ Sandy or gritty feeling	l □ Mucous discl □ Eye pain or s □ Glare or light	oreness		
Past or present eye h	istory (Check all that a	pply to your eyes):				
□ Cataracts □ Glaucoma □ Blindness □ Bell's Palsy	<ul> <li>□ Macular degeneration</li> <li>□ History of eye exercises</li> <li>□ Previous eye infections</li> <li>□ Retinal Detachment</li> </ul>			□ Crossed or turned eye		
Please list any eye drops	you are using (include OTC	C drops):				
Have you ever had any e	ye injuries? 🗆 Yes 🗀	No If yes, please explai	n:			
Have you ever had any e	ye surgeries? □ Yes □	No If yes, for:				
Do you do a lot of detail	ed near work, or work a lot	at a computer? □ Yes	□ No			
Hobbies:	Sports:		Leisure activi	ties:		
Do you wear glasses?	□ Yes □ No □ Never	Do you wear conta	act lenses?	□ No □ Never		
	AND EYE HISTORY	The state of the s				
This applies to <u>family more</u> B brother S sister):	embers. Please check yes of	r no for each condition. If	yes, list who it applies t	o (F father M mother		
Family Medical History	<b>/:</b>	Family Eye H	istory:			
Cancer:		Glaucoma		□ No		
Diabetes:	□ Yes □ No	Keratoconus:	□ Yes			
Heart Disease: High Blood Pressure:	□ Yes □ No	Macular Dege				
ingii biood i lessuic.		Retinitis Pigm	emosa. 🗆 Yes	□ No		
How many siblings (brot	hers and sisters)?					





## PERSONAL MEDICAL HISTORY

FE.	RSONAL MEDICAL INSTOR		granenna en					
	you have any allergies to any medica							
Do	you smoke/use tobacco currently?	□ Yes □ No	If yes, l	now often?				
Do	you drink alcohol?	□ Yes □ No	If yes,	how often?		<del></del>		
List	t any major injuries, surgeries and ho	spitalizations you ha	ave had: _	- <del> </del>				
Are	you pregnant?   Yes   No	f pregnant:	Weel	cs / Months	Are you nursing?	□ Yes □ No		
Are	you taking any prescription medica	tions?		□ Yes	□ No			
Are	you taking any over-the counter mo	edications?		□ Yes	□ No			
If y	es, please check the medical conditio	n and list the medic	ations be	low:		•		
	Disease / Condition	Medications		Diseas	se / Condition	Medications□□		
0					eeding problems			
	High blood pressure			Lupus	<b>9</b>			
	**			Fibromyalgia				
	Cholesterol problems			Sjogren's				
G	Stroke			Acne □ Eczen	na 🗆 Psoriasis			
_	** 1 11				go   Sarcoid lesions			
	Recent weight loss  gain			Rosacea	<b>5</b>			
	Fever			Shingles				
	Fainting   Dizziness			Arthritis (Oste	oarthritis)			
				Rheumatoid ar				
				Injury to joint				
0	Thyroid problems			Muscle pain				
	Graves disease			Headaches (mi	igraines)			
				Headaches (non-migraine)				
				□ Multiple sclerosis				
	Hormone imbalance			Parkinson's dis				
	Menopause			Alzheimer's di	sease			
	Diarrhea   Constipation			Siezures				
	Acid reflux			Cerebral palsy				
	Ulcer □ Stomach problems			ADD - ADHI	D			
	Colitis  Crohn's			Depression				
	Hepatitis   Liver problems		□	Anxiety				
	Bladder infections/problems		□	Insomnia				
	AIDS □ HIV positive			Other psychiat	ric problems			
	Syphilis   Gonorrhea   Herpes			Asthma	•			
	Kidney problems/kidney stones			Bronchitis				
	Birth control			Emphysema	COPD			
	Sinus problems/hay fever			Cystic fibrosis				
	Chronic cough			Sleep apnea				
	Hearing loss		_ <del>_</del>		oms or Conditions			
	Ear infection   Vertigo							
	Cancer, type							





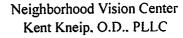
#### **Pupil Dilation and Optomap Imaging**

As part of a comprehensive eye exam our doctor looks at the retina, which is the tissue that lines the inside of the back of the eye. Viewing the retina is necessary to detect and prevent eye diseases that could lead to vision loss or blindness. Many diseases of the eye have no early symptoms and may not be detected without a thorough retinal exam. The view our doctor gets of your retina depends on the size of the **pupil**, which is the opening that regulates the amount of light entering the eye. When light is shined into the eye to evaluate the retina, the pupil normally constricts. This limits the view our doctor gets of your retina. So looking at the retina through an **undilated pupil** is a limited view.

A much more comprehensive view is obtained when the **pupil is dilated.** This is done with medical eye drops. If you choose dilating drops the side effects will include sensitivity to light, blurred near and occasionally blurred distance vision, depending on your prescription. These side effects will usually last for about 4 to 8 hours depending on the color of your eye and the strength of the eye drop. The dilated retinal exam is at **no extra charge.** Neighborhood Vision Center provides complimentary sun protection with a dilated exam.

Another comprehensive view of the retina is obtained with the retinal Optomap. The Optomap is painless, does not require eye drops and does not effect your vision. This is similar to taking a photograph, but it gives a much broader view of the retina than we get with a traditional camera. It gives us both a 2 and 3-dimensional images of your eye. The image of your retina is kept on file for comparison at subsequent visits. The Retinal Optomap is not usually covered by insurance and has a charge of \$35.

A dilated exan	and/or and Optomap is strongly reco	ommended by our doctor for an patients yearly.
Pupil dilation:	☐ Yes, I want pupil dilation	□ No, I do not want pupil dilation
Optomap:	☐ Yes, I want the Optomap retinal exam	□ No, I do not want the Optomap retinal exam
Patient / Guard	ian signature:	Date:





## SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT

**Consent to Treatment:** I hereby consent to any routine procedures, medical treatment or facility services rendered under the general and specific instructions from the attending Optometrist.

Release of Information: I hereby authorize any person/institution rendering care to furnish all information concerning this claim, as noted in the HIPAA Notice of Privacy Practices. Neighborhood Vision Center may disclose all or any part of my medical record and / or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV. to any person or corporation (1) which is or may be liable or under direct contract to Neighborhood Vision Center for reimbursement for services rendered, and (2) any health care provider for continued patient care. Neighborhood Vision Center may also disclose on any anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to state or federal law, statute or regulation. A copy of this authorization may be used in place of the original.

Financial Acknowledgement: I authorize payment for my vision and medical benefits directly to the Neighborhood Vision Center. I agree that if my employer, insurance carrier or plan sponsor (hereafter referred to as "plan") denies payment of all or any portion of my claim, I will be financially responsible for payment of all outstanding charges, subject to the agreement between the Neighborhood Vision Center and my plan.

Assignment of Benefits: I authorize the use of the signature below for all insurance submissions from the Neighborhood Vision Center and its doctors on my behalf.

Medicare: I request that payment of authorized Medicare benefits be made on my behalf to Kent Kneip, OD, PLLC, dba Neighborhood Vision Center, for services furnished me by Neighborhood Vision Center. 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 payable for related services. I understand my signature requests the payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in item 9 of the HCFA 1500 form or elsewhere on other claims forms, my signature authorizes releasing the information to the insurer or agency shown. Neighborhood Vision Center 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 deductibles are based upon the charge determination of the Medicare carrier.

Professional Fees: Professional fees are due upon completion of examination. Professional fees are non-refundable.

Insufficient Fund Policy: I understand and agree that if a check is returned for insufficient funds, the office will only accept cash or credit card payments thereafter, and I will be obligated to pay a returned check fee of \$25.00.

HIPAA Notice of Privacy Practices: I understand that I have been given the opportunity to view the Privacy Policy. I understand that if I desire a copy, one shall be given to me by the office staff. The policy is located on the table in the waiting area of the lobby. I understand that I may contact the HIPAA compliance officer at the Neighborhood Vision Center with any questions.

Beneficiary Signature or Authorized Party		Date			_
For staff use only: Reviewed registration info., med. hx, testing of	auth., & info. above: Tech Init	Dr. Init.	_ Date	# * # # # # # # # # # # # # # # # # # #	_