New Patient Registration

WELCOME TO OUR PRACTICE!!

Thank you for beginning your eye care journey with us! We strive to be the best medical, surgical and optometric team providing the highest quality eye care based on the latest ophthalmological advances. Compassion and personalized attention are our goals.

PLEASE PRINT CLEARLY

Date: _______________

Name:____Preferred Name / Nickname: ____________________

Gender at birth: ☐ Male ☐ Female ☐ I identify as: ____

Date of Birth: _______/________/_____________

Last Four of Social Security: ______________________

Address:____

Phone Number: (H) ( ) _________-_______________ (C) ( ) _________-_______________

Email : ____

In Case of Emergency

IN CASE OF AN EMERGENCY PLEASE CONTACT:

Name:____ Relationship to Patient: ________________________

Phone Number (H) or (C) : ( ) _________-_______________ (W): ( ) _________-_______________

Vision Insurance

ROUTINE VISION COVERAGE: (**select your plan name**):

Our Medical Doctors do NOT participate with vision plans. Our Optometrists are providers with ONLY these select vision plans listed below.

I understand that I am not being evaluated for any medical conditions today and only the routine examination requirements laid out under the provisions of my vision plan.

VSP / Eyemed / Davis Vision (Exam and Contacts)/ Cigna Vision/ Aetna Vision / some Humana Vision plans / I have no Vision Plan

Name of POLICY HOLDER (as on card) :____Policyholder DOB: _____/______/______

Relationship to Patient: ________________________

MILWAUKEE AVENUE
EYE CENTER

Medical Insurance(s)

PRIMARY:

Insurance Company Name: ____

Name of POLICY HOLDER (as on card) :____Policyholder DOB: _____/______/______

Relationship to Patient : _________________________

MAKE SURE TO PROVIDE ALL INSURANCE CARDS TO STAFF TO SCAN IN THE SYSTEM

SECONDARY:

Insurance Company Name: ____

Name of POLICY HOLDER (as on card) :____Policyholder DOB: _____/______/______

Relationship to Patient : _________________________

TERTIARY:

Insurance Company Name: ____

Name of POLICY HOLDER (as on card) :____Policyholder DOB: _____/______/______

Relationship to Patient : _________________________

Vision & Medical Insurance Assignment and Release

I, the undersigned, certify that either myself or my dependent have the aforementioned coverage. I am legally allowed to sign on behalf of the policyholder. Therefore, I hereby authorize the doctor and billing staff to release all necessary information to secure payment of the benefits, including but not limited to eligibility, prior authorizations, claims and appeals on my behalf. I authorize the use of this signature for all insurance submissions.

Signature of Policy Holder or Spouse: ____**Date** _________________

Financial Responsibility

I acknowledge it is my responsibility to provide the most current insurance information, including but not limited to ID changes, claims address and effective dates of coverage PRIOR to services being rendered to avoid being billed for the full amount of today's charges. I understand that I am financially responsible for all co-pays, deductibles, co-insurances and non-covered items. I understand that I am responsible for knowing the coverage offered by my insurances and plan requirements such as needing referrals. I understand that post billed charges that are due are to be paid in full unless other arrangements are made with the billing department. I acknowledge that failure to pay within 60 days of the first statement will result in release of information for collection proceedings. No Show Policy: I understand that if I do not provide notice prior to my appointment time, to cancel or reschedule, I will be charged a $50 fee.

Signature of Patient or Parent / Guardian: ____**Date** ________________

MILWAUKEE AVENUE EYE CENTER

Eye Health History

Please **check** all applicable

Blurred Vision - Distance	☐ Yes ☐ No	Flashes of Light	☐ Yes ☐ No
Blurred Vision - Near	☐ Yes ☐ No	Floaters / Spots	☐ Yes ☐ No
Burning Eyes	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	Lazy Eye	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Retinal Detachment	☐ Yes ☐ No
Dry Eye(s)	☐ Yes ☐ No	Macular Degeneration	☐ Yes ☐ No
Discharge	☐ Yes ☐ No	Loss of Vision	☐ Yes ☐ No

Medical History

Please **CHECK** all applicable

Ankylosing Spondylitis	Fibromyalgia	Lupus	Rosacae
Arthritis	Headaches	Multiple Sclerosis	Seizures
Atrial Fibrillation	Heart Attack	Parkinson's Disease	STD
Diabetes	HIV / AIDS	Prostate Disorders	Other:______________
Cancer: ____________	Lung Disease	Rheumatoid Arthritis	Other:______________

Allergies

☐ No Known Allergies

Eye & General Surgeries

☐ No surgeries	
	Year:
	Year:
	Year:
	Year:

Primary Doctor Information

Primary Doctor (First & Last Name):____________________________________ Phone Number: (   ) ______- ____________

Current Medications

Please **LIST all OR check the box** NO MEDICATIONS

☐ **NO MEDICATIONS** **OR** ☐ **LIST PROVIDED TO STAFF**

Acknowledgement of Receipt of Notice of Privacy Practices

We are required by law to maintain the privacy of and provide individuals with, the notice of our legal duties and privacy practices with respect to protected health information.

I, ____, have received the NOTICE OF PRIVACY PRACTICES from Milwaukee Avenue Eye Center.

Preferred Method Of Contact: ☐ Home ☐ Cell ☐ Place of Employment

I DO allow _____ **DO NOT allow _____** **:** Detailed messages left on my voicemail.

I give my permission for the doctor and staff to speak with :

Name ____________________________ ______________ (Relationship to You)

Name ____________________________ ______________ (Relationship to You)

Name ____________________________ ______________ (Relationship to You)

____________________________________ Signature

______________________ Date

____________________________________ Signature of Parent / Legal Guardian OR Representative

______________________ Relationship to Patient

______________________ Date

Copy of HIPAA policy available upon request