

**JANSEN OPTICAL
NEW PATIENT REGISTRATION FORM**

PATIENT INFORMATION (PLEASE PRINT)

TODAY'S DATE:

Circle One	First Name:	Middle Initial:	Last Name:	SSN: XXX- XX - _____
Mr. Ms. Mrs. Dr.				DOB: ___/___/___ Age: ___

Street Address:	City/State:	Zip Code:
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Primary Contact # (Cell, Home, Work)	Secondary Contact #:(Cell, Home, Work)	Emergency Contact Name & Number.:
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Email Address:	Occupation/Grade	Employer/School
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Whom may we thank for referring you to our office?

<input type="checkbox"/> Annual Postcard	<input type="checkbox"/> Insurance	<input type="checkbox"/> Website	<input type="checkbox"/> Google	<input type="checkbox"/> Doctor	<input type="checkbox"/> Yelp
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MEDICAL INFORMATION

Chief Complaint (Reason for today's visit):

Please check boxes if you experience any of the following:

Watery or itchy Eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Floaters/Spots	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Blurry Vision Distance	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dry Eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Blurry Vision Near	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Flashes of Light	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Light Sensitivity	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Eye Pain/Strain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Double Vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Night Blindness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pink or Red Eye	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Please list all current medications:(including eye medications)

Height: ___ft___inches Weight: _____lbs Do you smoke? Yes No Do you drink alcohol? Yes No

Allergies to Medications: _____ Females: Are you pregnant? Yes No

Primary Care Provider _____ **Phone:** _____

Preferred Pharmacy & Location: _____ **Phone:** _____

Check all diagnoses and symptoms that apply :	Check if you have difficulties with any of the following:
Diabetes If Self, Year Diagnosed: _____ <input type="checkbox"/> Type I <input type="checkbox"/> Type II	Recent fever, weight loss/gain, fatigue <input type="checkbox"/> Yes <input type="checkbox"/> No
Lasik Surgery/Eye Injury Date of Surgery: _____	Ears/Nose/Throat <input type="checkbox"/> Yes <input type="checkbox"/> No
High Blood Pressure	Cardiovascular <input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Disease	Respiratory <input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	Genital, Kidney, Bladder <input type="checkbox"/> Yes <input type="checkbox"/> No
Thyroid	Muscles, Bones, Joints <input type="checkbox"/> Yes <input type="checkbox"/> No
Seasonal Allergies	Skin <input type="checkbox"/> Yes <input type="checkbox"/> No
Eye History	Neurological <input type="checkbox"/> Yes <input type="checkbox"/> No
Cataracts	Psychiatric <input type="checkbox"/> Yes <input type="checkbox"/> No
Strabismus/Amblyopia/Lazy Eye	Endocrine <input type="checkbox"/> Yes <input type="checkbox"/> No
Glaucoma	Blood/Lymph <input type="checkbox"/> Yes <input type="checkbox"/> No
Macular Degeneration/Retinal Defects	Allergic/Immunologic <input type="checkbox"/> Yes <input type="checkbox"/> No

Please sign below to indicate that all the information above is correct:

Patient/Guardian Signature: X _____ **Date:** ___/___/___ Revised 10/15/2018

For Office Use only:

Dr.'s Signature: _____ Technician's Initials: _____

NOTICE TO ALL PATIENTS USING INSURANCE:

Proof of insurance is to be presented at time of exam. We do not retro bill claims.

Major Medical Insurance Provider: _____

Vision Service Provider: _____

Primary Insured's Full Name: _____

Primary Insured's Date of Birth: _____

I hereby authorize direct remittance of payment for all insurance benefits to Cheryl Jansen, OD and Associates for all covered medical services and supplies provided to me during all courses of treatment and care provided while under their care.

I understand that insurance billing is a service provided as a courtesy, and that I am at all times financially responsible for any charges not covered by my health care benefits. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. A quote of benefits by the insurer is not a guarantee of payment. We will file your insurance claim, but not all insurance plans cover all services. In the event your insurance carrier determines a service "not covered" or "applied to deductible", you are responsible for payment.

Patient/Guardian Initials _____

Financial Responsibility:

I understand and acknowledge that I am accepting full financial responsibility for all payment for medical or vision services and/or supplies. **Any unpaid balance over 120 days will be sent to a collections agency and a 30% collection fee will be added to the balance due.**

Patient/Guardian Initials _____

Acknowledgement of Privacy Practices:

I have been provided with a copy of the Notices of Privacy Practices for Cheryl Jansen, OD and Associates effective date of July 1, 2013.

I understand my medical records are confidential and that by signing this consent form I am allowing my medical information to be released upon my insurance provider's request for the purpose of Health Care Operations. Phone/text messages and email may be used to contact me, and I can opt out of these contact methods at any time with written request. I understand that if I have questions or complaints that I should contact the Privacy Officer.

Patient/Guardian Initials _____

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient/Guardian

Signature _____

Date

Rev 6/2018TMR

CONTACT LENS PATIENTS:

Contact lens prescriptions fall under the criteria of a drug prescription. This means FDA regulations apply. **A contact lens prescription is valid for only one year.** Thereafter an annual comprehensive eye examination and contact lens fitting will be required to update the contact lens prescription and purchase contact lenses.

Contact lens fitting fee:

- Covers the extra tests performed by the doctor
- Covers any contact lens fit related follow-up visits for 90 days
- Includes a pair of trial lenses

Most insurance companies consider contact lenses as an elective vision correction and do not cover the cost of the fitting fee. Some insurance companies may allow you to apply your contact lens material allowance toward the contact lens fitting fee.

Patient/Guardian Initials _____

Optomap Screening

Sight threatening diseases including Glaucoma, Macular Degeneration, and Diabetes often have no outward symptoms in early stages. This technology offers unparalleled views of the retina. **The cost of this screening is \$39.00.**

- In most cases, the Optomap Screening will replace traditional dilation; **however, there are instances where dilation is required by your insurance carrier or if you have diabetes.**
- There are no lasting side effects to the Optomap; the image is available immediately for review, and is stored electronically for monitoring changes in retinal health.

_____ Yes, I agree to have the Optomap Retinal Exam

_____ No, I would prefer dilation* (*requires an additional 20-30 minutes in the office*)

***Medicare requires dilation for a comprehensive eye exam. You may still have the Optomap Retinal exam in addition to dilation for exam records.**

Revised 07/01/2019