JANSEN OPTICAL

PATIENT REGISTRATION FORM

PATIENT INFORMATION (PLEASE PRINT)

TODAY'S DATE:

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

Street Address:	City/State:	Zip Code:

Primary Contact # (Cell, Home, Work)	Secondary Contact #:(Cell, Home, Work)	Emergency Contact Name & Number.:
Email Address:	Occupation/Grade	Employer/School

Whom may we thank for referring you to our office?

☐Annual Postcard	☐Insurance	☐Website	☐Google	☐Doctor	☐Yelp

MEDICAL INFORMATION

Chief Complaint (Reason for today's visit):

Please check boxes if you experience any of the following:

Watery or itchy Eyes	☐Yes	☐ No	Floaters/Spots	☐Yes	☐ No	Blurry Vision Distance	☐Yes	☐ No
Dry Eyes	☐Yes	☐ No	Headaches	☐Yes	☐ No	Blurry Vision Near	☐Yes	☐ No
Flashes of Light	☐Yes	☐ No	Light Sensitivity	☐Yes	☐ No	Eye Pain/Strain	☐Yes	☐ No
Double Vision	☐Yes	☐ No	Night Blindness	☐Yes	☐ No	Pink or Red Eye	☐Yes	☐ 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:_____** **☐Type I ☐Type II**	☐**Self**	☐ **Family**	**Recent fever, weight loss/gain, fatigue**	☐Yes ☐No
Lasik Surgery/Eye Injury **Date of Surgery:_____**	☐Yes	☐No	**Ears/Nose/Throat**	☐Yes ☐No
High Blood Pressure	☐Yes	☐No	**Cardiovascular**	☐Yes ☐No
Heart Disease	☐Yes	☐No	**Respiratory**	☐Yes ☐No
Arthritis	☐Yes	☐No	**Genital, Kidney, Bladder**	☐Yes ☐No
Thyroid	☐Yes	☐No	**Muscles, Bones, Joints**	☐Yes ☐No
Seasonal Allergies	☐Yes	☐No	**Skin**	☐Yes ☐No
Eye History			**Neurological**	☐Yes ☐No
Cataracts	☐**Self**	☐ **Family**	**Psychiatric**	☐Yes ☐No
Strabismus/Amblyopia/Lazy Eye	☐**Self**	☐ **Family**	**Endocrine**	☐Yes ☐No
Glaucoma	☐**Self**	☐ **Family**	**Blood/Lymph**	☐Yes ☐No
Macular Degeneration/Retinal Defects	☐**Self**	☐ **Family**	**Allergic/Immunologic**	☐Yes ☐No

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

Patient/Guardian Signature: X_____ **Date:** _____/_____/_____ Rev:12/01/2021

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

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.**

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_____

I received a copy of my contact lens prescription, and I consent to receive my contact lens prescription electronically. I understand that this prescription will be sent by encrypted email to the email address on file, which I have confirmed is correct.

_____Date_____