Patient Registration Form
Welcome to Our Office!

Date_____
Name: Last_____First_____M_____Name You Go By_____
Sex: Male___ Female____ Date of Birth_____ Social Security #_____
Mailing Address_____Street Address_____
City_____State_____Zip_____
Home Phone_____Work Phone_____Ext._____
Cell Phone_____ Cell Phone Carrier_____ Preferred Number _____
Email Address _____
Place of Employment_____Job Title_____
Race: (Check One) African American ___ Am. Indian __ Asian __ Hispanic __ White __ Other __ Prefer not to answer ___
Primary Language _____
Marital Status: Married__ Single___ Divorced___ Widow___
Spouse's Name_____ Spouse's Employer: _____
Spouses SS# _____ Spouse's Date of Birth: _____
In case of emergency, please notify_____
Relationship_____ Phone #_____

If the patient is a minor, please list parent or guardian information below:
Parent/Guardian Name_____
Employment_____ **Phone**_____

Referred by _____
Please list family members who are patients at this office: _____

PAYMENT DUE WHEN SERVICES ARE RENDERED
WE ACCEPT CASH, CHECK, MASTERCARD, VISA OR DISCOVER

INSURANCE INFORMATION

Medicare #_____ Medicaid #_____

Supplement to Medicare Company_____ #_____
(MEDICARE SUPPLEMENTS WILL BE FILED BUT IF NOT PAID WITHIN 60 DAYS PATIENT MAY BE BILLED)

Group Insurance (Most insurances do not pay for routine eye exams or glasses.)
Company _____ Policy#_____
Policy Holder_____ Policy Holder's Date of Birth_____

Was this an accident? Yes No Date of Accident _____ Work Related? Yes No

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MEDICAL HISTORY QUESTIONNAIRE

Name:_____ Date:_____

Current Eye Medications (including OTC):_____

Current General Medications:_____

_____

_____

Allergies to Medicines:_____

Other Allergies:_____

Describe all serious illnesses, injuries and surgeries:_____

_____

Primary Care Physician:_____ Phone#:_____

FAMILY HISTORY

Please note any family member with the following diseases/conditions
M-mother, F-father, S-sibling, GP-grandparent

		YES	NO			YES	NO
Arthritis	____	☐	☐	Diabetes	____	☐	☐
Blindness	____	☐	☐	Glaucoma	____	☐	☐
Cancer	____	☐	☐	Heart Disease	____	☐	☐
Cataracts	____	☐	☐	Hypertension	____	☐	☐
Crossed Eyes	____	☐	☐	Retinal Dz.	____	☐	☐

SOCIAL HISTORY

Health Habits
Check which substances you use and the consumption.

	YES	NO
Alchohol Quantity:_____	☐	☐
Drugs Quantity:_____	☐	☐
Tobacco Quantity:_____	☐	☐

Social History
Please indicate hobbies and interest:

	YES	NO
Computers	☐	☐
Fishing	☐	☐
Golfing	☐	☐
Hunting	☐	☐
Music	☐	☐
Reading	☐	☐

REVIEW OF SYSTEMS

PLEASE MARK EACH QUESTION YES OR NO AS PERTAINS TO PATIENT

	YES	NO
EYES		
Cataracts	☐	☐
Contacts	☐	☐
Crossed Eyes (Amblyopia)	☐	☐
Double Vision	☐	☐
Flashes/Floaters in vision	☐	☐
Glasses	☐	☐
Glaucoma	☐	☐
Loss of Vision	☐	☐
Retinal Disease	☐	☐
BONE/JOINT/MUSCLE		
Arthritis	☐	☐
Joint/Muscle Pain	☐	☐
Polio	☐	☐
CANCER _____		
Breast	☐	☐
Lung	☐	☐
Prostate	☐	☐
Skin	☐	☐
Other	☐	☐
CONSTITUTIONAL		
Fever	☐	☐
Weight Gain/Loss (sudden)	☐	☐
ENDOCRINE		
Diabetes	☐	☐
Thyroid Abnormalities	☐	☐
EAR, NOSE AND THROAT		
Hard of Hearing	☐	☐
Chronic Cough	☐	☐
Dry Mouth/Throat	☐	☐
Hay Fever	☐	☐
Sinus Congestion	☐	☐
GASTROINTESTINAL (Stomach)		
Constipation	☐	☐
Diarrhea	☐	☐
Ulcers	☐	☐

	YES	NO
GENITOURINARY		
Chlamydia	☐	☐
Gonorrhea	☐	☐
Kidney Disease	☐	☐
Syphilis	☐	☐
INTEGUMENTARY (Skin)		
Eczema	☐	☐
Psoriasis	☐	☐
Rash	☐	☐
LYMPHATIC/HEMATOLOGIC		
AIDS	☐	☐
Anemia	☐	☐
Bleeding Disorders	☐	☐
Hepatitis	☐	☐
Herpes	☐	☐
HIV Positive	☐	☐
Liver Disease	☐	☐
NEUROLOGIC		
Alzheimers	☐	☐
Epilepsy	☐	☐
Headaches	☐	☐
Migraines	☐	☐
Multiple Sclerosis	☐	☐
Seizures	☐	☐
PSYCHIATRIC		
Depression	☐	☐
High Anxiety	☐	☐
REPRODUCTIVE		
Pregnant	☐	☐
RESPIRATORY		
Asthma	☐	☐
Chronic Bronchitis	☐	☐
Emphysema	☐	☐
Pneumonia	☐	☐
Tuberculosis	☐	☐
VASCULAR		
Heart Disease	☐	☐
High Blood Pressure	☐	☐
High Cholesterol	☐	☐
Stroke	☐	☐

FOR OFFICE USE

Reviewed:_____ Reviewed:_____ Reviewed:_____

Reviewed:_____ Reviewed:_____ Reviewed:_____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

The law requires that Wesson Ophthalmology Associates / Mothershed Optometry Associates make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

PLEASE CHECK *ONLY ONE*

☐ I **have read** or had explained to me Wesson Ophthalmology Associates/Mothershed Optometry Associates Notice of Privacy Practice and ***agree to continue my care* with Wesson Ophthalmology Associates/Mothershed Optometry Associates under said terms**. (A copy is available at the front desk.)

☐ **I was given** the opportunity to read Wesson Ophthalmology Associates/Mothershed Optometry Associates Notice of Privacy Practice and **declined but wish to continue my care with Wesson Ophthalmology Associates/Mothershed Optometry Associates under said terms**.

☐ I have read or had explained to me Wesson Ophthalmology Associates/Mothershed Optometry Associates Notice of Privacy Practice and ***do not wish to continue my care*** with Wesson Ophthalmology Associates/Mothershed Optometry Associates under said terms.

☐ The Notice of Privacy Practice could not be read due to the emergent nature of the care or other reason described as. _____

_____ _____

Patient Signature Date

If patient is a **minor** or you are patients **power of attorney** (must provide documentation), please sign as a personal representative of the patient; please indicate your relationship.

_____ _____

Representative Relationship to Patient

According to federal law, this office is not allowed to release any information on you without your consent. Please list anyone we may speak to on your behalf. ***We cannot speak to spouse, parents, doctors office, or children without your written consent.***

NAME	PHONE NUMBER	RELATIONSHIP TO PATIENT

SIGNATURE ON FILE, ASSIGNMENT OF BENEFITS, FINANCIAL AGREEMENT

Patient Name (Beneficiary) Insurance Number

1. **Medicare:** I request that payment of authorized Medicare benefits be made on my behalf to Wesson Ophthalmology Asso., PLLC or Mothershed Optometry Asso., PLLC, for services furnished me by Wesson Ophthalmology Asso., PLLC or Mothershed Optometry Asso., PLLC. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) and its agents any information needed to determine these benefits or the 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 Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Wesson Ophthalmology Asso., PLLC or Mothershed Optometry Asso., PLLC accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier. **I understand that Refraction is a non-covered charge with Medicare and that I will be responsible for the cost of $25.00 or $40.00 for complex refraction.**

2. **MEDIGAP:** I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, 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 Wesson Ophthalmology Asso., PLLC or Mothershed Optometry Asso., PLLC, if possible or otherwise to me.

3. **RELEASE OF INFORMATION:** Wesson Ophthalmology Asso., PLLC or Mothershed Optometry Asso., PLLC 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 contract to Wesson Ophthalmology Asso., PLLC or Mothershed Optometry Asso., PLLC for reimbursement for services rendered, and (2) any health care provider for continued patient care. Wesson Ophthalmology Asso., PLLC or Mothershed Optometry Asso., PLLC may also disclose on an 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.

4. **NON-COVERED SERVICES:** I understand that Wesson Ophthalmology Asso., PLLC or Mothershed Optometry Asso., PLLC contracts with health care service plans relate only to items and services which are "covered" by the health care services plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient; and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with Wesson Ophthalmology Asso., PLLC or Mothershed **Optometry** Asso., PLLC to obtain necessary health care service plan authorizations.

5. **FINANCIAL AGREEMENT:** I agree that in return for the services provided to the patient by Wesson Ophthalmology Asso., PLLC or Mothershed Optometry Asso., PLLC, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Wesson Ophthalmology Asso., PLLC or Mothershed Optometry Asso., PLLC for payment. **If an account is sent to a collection 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 insuring the patient, or any other party liable to the patient, is hereby assigned to Wesson Ophthalmology Asso., PLLC or Mothershed Optometry Asso., PLLC. If copayments and /or deductibles are designated by my insurance company or health plan, I agree to pay them to Wesson Ophthalmology Asso., PLLC or Mothershed Optometry Asso., PLLC . **However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.**

Patient's Signature or Authorized Party **Date**