



Name: \_\_\_\_\_ Date: \_\_\_\_\_

Thank you for choosing Gulf Coast Eye Center. Please take a minute to let us know how you were referred to our practice. **(PLEASE X or ✓ ONLY ONE BOX)**



Phone Book

• Which Phone Book? \_\_\_\_\_



Newspaper

• Which Newspaper? \_\_\_\_\_



Radio

• Which Station? \_\_\_\_\_



Physician

• Doctor's Name: \_\_\_\_\_



Optometrist

• Optometrist's Name: \_\_\_\_\_



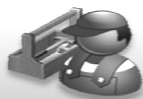
Insurance Company

• Name of Insurance Company: \_\_\_\_\_



Friend or Family Member

• Name of Person: \_\_\_\_\_



Workman's Comp

• Name of Employer: \_\_\_\_\_



Emergency Room

• Name of Hospital: \_\_\_\_\_



Other (please list) \_\_\_\_\_

# Gulf Coast Eye Center REGISTRATION FORM

(PLEASE PRINT)

Today's Date: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

## PATIENT INFORMATION

Patient's Last Name		First	Middle	<input type="checkbox"/> Mr.	Marital Status		
				<input type="checkbox"/> Mrs.	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced
				<input type="checkbox"/> Ms.	<input type="checkbox"/> Separated	<input type="checkbox"/> Widow	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former Name)			Birth Date / /	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Social Security #		E-Mail Address			Home Phone No. ( )		
Street		City		State	Zip		
Occupation	Employer			Employer Phone No. ( )			

### Best Phone Number to Reach You At and Time of Day

Referred to Clinic by (Please check one box)

<input type="checkbox"/> Dr. _____	<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Hospital
<input type="checkbox"/> Other _____	<input type="checkbox"/> Friend / Family	<input type="checkbox"/> Yellow Pages
<input type="checkbox"/> Close to Home/Work	<input type="checkbox"/> Radio	

## INSURANCE INFORMATION

(please give your insurance card and driver's license to the receptionist)

Is the patient covered by insurance?  Yes  No

**Name of Primary Insurance:**  Medicare  Medicaid  BCBS  Other: \_\_\_\_\_

Subscriber's Name	Subscriber's S.S.#	Birth Date / /	Policy #	Group#
Patient's Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____				
<b>Name of Secondary Insurance (If Applicable)</b> _____				
Subscriber's Name	Subscriber's S.S.#	Birth Date / /	Policy #	Group #
Patient's Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____				

## COMPLETE ONLY IF PATIENT IS UNDER 18 YEARS OF AGE

Father's Name	Father's S.S. #	Birth Date / /	Employer	Work Phone #
Street Address		City	State	Zip
Phone #				
Mother's Name	Mother's S.S. #	Birth Date / /	Employer	Work Phone #
Street Address		City	State	Zip
Phone #				

## IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Patient	Home Phone #	Work Phone #
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X \_\_\_\_\_

**Patient/Guardian Signature**

**Date**

# Medical History Questionnaire

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_

Date of last eye exam: \_\_\_\_\_ Do you wear glasses? Yes No Do you wear contacts? Yes No

List any **medications** you currently take (Rx an over-the-counter) \_\_\_\_\_

Do you have **allergies** to any medications? Yes No If yes, list the medications: \_\_\_\_\_

List any **surgeries** you have had (cataract, appendectomy) \_\_\_\_\_

**Do you currently have any problems in the following areas? If YES, Please Provide additional Information.**

	YES	NO	DETAILS
<b>EYES</b> (poor vision, eye pain, tearing, redness, etc.)			
<b>GENERAL / CONSTITUTIONAL</b> (fever, heat stroke, weight loss, weight gain, unusually tired)			
<b>EARS, NOSE, THROAT</b> (hard of hearing, stuffy nose, ear ache, cough, dry mouth, etc.)			
<b>CARDIOVASCULAR</b> (high BP, racing pulse, etc.)			
<b>RESPIRATORY</b> (congestion, wheezing, short of breath, etc.)			
<b>GASTROINTESTINAL</b> (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)			
<b>GENITAL, KIDNEY, BLADDER</b> (painful urination, frequent urination, impotence, yellow jaundice, etc.)			
<b>FEMALES</b> Are you pregnant? Nursing?			
<b>MUSCLES, BONES, JOINTS</b> (joint pain, stiffness, swelling, cramps, arthritis, etc.)			
<b>SKIN</b> (pimples, warts, growths, rash, etc.)			
<b>NEUROLOGICAL</b> (numbness, headache, seizures, paralysis, etc.)			
<b>PSYCHIATRIC</b> (anxiety, depression, insomnia)			
<b>ENDOCRINE</b> (diabetes, hypothyroid, etc.)			
<b>BLOOD / LYMPH</b> (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)			
<b>ALLERGIC / IMMUNOLOGIC</b> (sneezing, swelling, redness, itching, hives, lupus, etc.)			

**FAMILY HISTORY** (Mother, Father, Grandparent, Sibling)

Has any member of your family had these diseases? *(circle all that apply)*

Blindness	Cataract	Glaucoma	Diabetes	Hypertension
Heart Disease	Stroke	Cancer	Arthritis	Thyroid Disease

Any other heritable disease? \_\_\_\_\_

**SOCIAL HISTORY**

Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)? YES NO

Have you ever had a blood transfusion? YES NO

Do you drink alcohol? YES NO If YES, how much? \_\_\_\_\_

Do you smoke? YES NO If YES, how much? \_\_\_\_\_ How many years? \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

Reviewed by: (Please initial and date) \_\_\_\_\_

\_\_\_\_\_



## Lifestyle Questionnaire

To help us assist you in selecting your best vision correction options, please fill out this brief questionnaire.

Name: \_\_\_\_\_ Date Completed: \_\_\_\_\_

Occupation: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  Male  Female

1.) What is your primary visual concern? \_\_\_\_\_

2.) I currently wear:  Eyeglasses  Contacts  Sunglasses

3.) What would you most like to improve about your vision wear? \_\_\_\_\_

4.) What recreational hobbies, activities, or interests do you enjoy? **Check all that apply.**

- |                                      |  |                                       |                                       |                                   |
|--------------------------------------|--|---------------------------------------|---------------------------------------|-----------------------------------|
| <input type="checkbox"/> Golf        | <input type="checkbox"/> Running           | <input type="checkbox"/> Racquetball  | <input type="checkbox"/> Football     | <input type="checkbox"/> Tennis   |
| <input type="checkbox"/> Snow Skiing | <input type="checkbox"/> Baseball/Softball | <input type="checkbox"/> Boating      | <input type="checkbox"/> Water Sports | <input type="checkbox"/> Fishing  |
| <input type="checkbox"/> Basketball  | <input type="checkbox"/> Reading           | <input type="checkbox"/> Gardening    | <input type="checkbox"/> Knitting     | <input type="checkbox"/> Crafts   |
| <input type="checkbox"/> Watching TV | <input type="checkbox"/> Cooking           | <input type="checkbox"/> Video Games  | <input type="checkbox"/> Painting     | <input type="checkbox"/> Internet |
| <input type="checkbox"/> Sewing      | <input type="checkbox"/> Woodworking       | <input type="checkbox"/> Other: _____ |                                       |                                   |

5.) What job requirements do you have? **Check all that apply.**

- |   |   |
|---|---|
| <input type="checkbox"/> Computer Work        | <input type="checkbox"/> I Work Outdoors                    |
| <input type="checkbox"/> Considerable Reading | <input type="checkbox"/> My Job Necessitates Safety Eyewear |
| <input type="checkbox"/> Other: _____         |   |

6.) Can you read without glasses?  yes  no

7.) Do you mind wearing glasses?  yes  no

8.) Do you consider yourself sensitive to sunlight?  yes  no

9.) Do you have difficulty driving at night?  yes  no

10.) Do you have problems with glare at night time?  yes  no

11.) Are you interested in LASIK to correct nearsightedness, farsightedness, and astigmatism?

yes (*please answer next question*)

no (*please stop here*)

12.) Choose the statement that best reflects your lifestyle:

I would prefer better distance vision even if I need to wear “readers” for near vision activities (i.e. reading, applying make-up, computer work)

I need to see up close so much of the time and would be willing to trade-off better distance vision if I can avoid the use of “readers”

# GULF COAST EYE CENTER

## Signature on File, Assignment of Benefits, Financial Agreement, HIPAA Notice

**1. MEDICARE and MEDIGAP:** I request that payment of authorized Medicare and Medigap benefits be made on my behalf to Gulf Coast Eye Center for services furnished me by Dr. Rawlings, Dr. Bowie, Dr. Dodson, or Dr. Ebrahim. 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 or 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, my signature authorizes releasing the information to the insurer or agency shown. Gulf Coast Eye Center accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

**2. OTHER INSURANCE:** I authorize payment of my medical, surgical, and vision insurance benefits to Gulf Coast Eye Center. I understand I am financially responsible for any charges whether or not paid by said insurance. After 60 days from date of service if payment has not been received from my insurance company, the balance becomes my responsibility. Any conflicts with my insurance company will have to be handled by me. I agree to pay any co-payments and/or deductibles designated by my insurance company or health plan to Gulf Coast Eye Center. I authorize Gulf Coast Eye Center to release any information required to process any and all claims for reimbursement on my behalf. A copy of this authorization may be used in place of the original.

**3. NON-COVERED SERVICES:** I understand that Gulf Coast Eye Center's contract with health care services plans (i.e., HMOs, PPOs) relates only to items and services which are "covered" by the health care service plans. Accordingly, I accept full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. **Charges for refractions are due at time of service.** Refraction is a measurement of the lens power necessary to prescribe glasses or other corrective lenses. Most medical insurances do not cover this as they consider it to be a routine service. Failure to pay for the refraction at time of check out will result in your prescription being held until payment is received. I agree to cooperate with Gulf Coast Eye Center to obtain necessary health care service plan authorizations. If you have Medicare, but Medicare may deem the prescribed treatment as "medically unnecessary" according to HCFA payment guidelines, you will be requested to sign a waiver (advance beneficiary notice) prior to treatment and payment for the service is due at the time of service.

**4. FINANCIAL AGREEMENT: Payment is due at time of service.** We accept cash, personal checks, debit and credit cards. All deductibles, co-pays, and non-covered services are due at time of service unless payment arrangements have been made in advance. All Medicare patients will be required to pay the 20% co-pay based upon the current Medicare Fee Schedule, at the time of service, unless proof of a secondary policy is evident. Patient balances unforeseen at time of service will be billed to the address you have provided for billing purposes. It is your responsibility to inform us of any change in address, phone, or employment. All balances are due in full within 14 days of the billing date. If you cannot pay the balance in full within 14 days, please contact our office to see if you qualify for any special payment arrangement options. Our office treats patients regardless of financial status. If you have no insurance, have maximized your benefits, have a high deductible, or you are currently medically indigent or financially indigent but not eligible for Public Assistance or Medicaid, please ask to speak with the Financial Manager. You will need to provide a copy of last year's tax returns and current pay check stubs to be considered for assistance with our office.

**I agree that in return for the services provided to me by Gulf Coast Eye Center, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Gulf Coast Eye Center for payment. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Gulf Coast Eye Center. However, I understand that I am primarily responsible for the payment of my bill. If my account is sent to an 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.**

**5. HIPAA NOTICE OF PRIVACY PRACTICES:** I acknowledge that I have received the Notice of Privacy Practices issued by Gulf Coast Eye Center that was effective April 14, 2003.

X

Name of Patient

Signature or Authorized Party

Date