



Acct# Patient Information

Patient Name:				Home Telephone:			
Social Security Number:				Work Telephone #:			
Sex	Race	Language	Ethnicity	Cell Telephone #:			
Date of Birth:		Age		eMail:			
Address:				Emergency Contact Name & Phone:			
City, State & Zip Code:				Relationship to Patient:			
Family Physician Name/Address/Phone:				Referring Physician Name/Address/Phone:			
Employer Name/Address:				Student Status:		Marital Status:	
<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired				<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time		<input type="checkbox"/> Married <input type="checkbox"/> Single	
Pharmacy Name/Address/Phone/Fax:				Medicare Patients: Do you currently reside in a Skilled Nursing Facility? YES NO Facility Name:			

Insurance Information

	Insurance Company	Subscriber	Subscriber DOB	Relationship
Primary				
Secondary				
Tertiary				
Vision Plan				

Financially Responsible Person (For all patients under 18 years of age. Parent bringing MINOR child to office.)

Full Name:		Social Security Number:		
Address:		Home Telephone #:		
City, State & Zip Code:		Work Telephone #:		
Date of Birth (mm/dd/yyyy):		Cell Telephone #:		
Relationship to Patient:		<input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Other		

Insurance Authorization and Assignment of Benefits

I certify that the information that I have reported with regards to my insurance coverage is correct. I also authorize the release of any medical information necessary to process this claim. I also authorize payment of medical benefits to Ocean Eye Institute for services provided. I fully understand that payment for services is not contingent upon recovery and this does not relieve me of my primary obligation to pay.

Medicare Patients

If you are covered by Medicare, please read and sign the following:

In Medicare cases, Ocean Eye Institute agrees to accept the charge determination of Medicare as the full charge, and the patient is responsible only for deductible, coinsurance and non-covered services. Coinsurance and the deductibles are based upon the charge determination of Medicare.

Covered Benefits: As a courtesy, we will verify and file your claim with your insurance carrier, however we cannot guarantee payment. You are responsible for payment of any deductible, co-payment/coinsurance, and any non-covered services as determined by your contract with your insurance carrier. Many insurance companies have additional stipulations that may affect your coverage. If your insurance company denies any part of your claim, payment will be expected from you. Verification is only an explanation of benefits based upon information that we received from your insurance carrier. It is not a guarantee of payment. Please contact your insurance carrier directly to confirm your individual benefits for services and verify referral/authorization requirements.

Co-Payments: Co-payments and Co-insurance amounts must be paid at each visit according to your insurance contract. Please plan accordingly. We accept cash, checks and credit cards (Visa, Master Card, American Express or Discover).

Medicare Program: Our practice participates in the Medicare program. We will collect the **20% not covered** by Medicare at the time of your visit. Since you are also responsible to meet your Medicare deductible, we will need to collect that amount as well.

Refraction Fee: A "Refraction" is a standard part of your eye exam. This test is necessary to determine your eyeglass prescription; however, it is NOT COVERED by MEDICARE and MOST COMMERCIAL insurance Plans. A refraction fee of \$47 will be collected at the time of your visit.

I have read the above statements. It is my understanding that I am financially responsible to Ocean Eye Institute for the services provided to me or my dependent. I authorize my insurer to pay any benefits directly to Ocean Eye Institute. I agree to pay the full amount of all charges incurred by the above named patient that are not covered by my insurance carrier.

Patient Signature or If the Patient is a minor Parent/Guardian Signature

 Date



Patient Name: _____ Acct#: _____

Ocean Eye Institute Notice of Privacy Practices

I acknowledge that Ocean Eye Institute has provided me with a copy of their Privacy Notice.

Signature _____ Date _____

I hereby authorize Ocean Eye Institute to release medical and/or financial information to the following person (ex. Spouse, Parent, Child, Doctor, Friend, etc):

Name _____ Relationship _____

Name _____ Relationship _____

Signature _____ Date _____

**PATIENT RESPONSIBILITY
FOR FOLLOW-UP CARE PLEDGE**

I hereby acknowledge and understand that even with the best training, skill and experience, a medically trained professional is not always capable of solving my medical problems. Therefore, I understand it is important that any and all recommendations by doctors are followed completely in order to increase the likelihood of a positive and healthy treatment/outcome. I acknowledge and understand that if any physician in this office prescribes medicine to me that the proper taking of any such medicine shall be my sole responsibility (or my guardian who has attended this consultation). I agree to properly follow the prescribed dosage and frequency amounts of these medicines as recommended by my doctor.

I understand that if a doctor in this office refers me to see another doctor or receive another test including, but not limited to, a blood test, an MRI, or CT Scan, this timely recommendation is important and essential to the ultimate success of my treatment/outcome. I understand that it is not possible for any person in this office to constantly follow-up to ensure that I have followed these recommendations. Therefore, I understand that if I fail to see that specialist or obtain the test for which I was referred immediately, this can risk my current health or increase future health risks.

I understand that it is solely my responsibility to follow any of the medical advice given by any medical person in this office and any bad health outcome from my failure to follow the advice of my doctors should be expected.

Patient Signature: _____ Date: _____



Patient Name: _____ Acct#: _____ Date: _____

HEALTH QUESTIONNAIRE

What brings you to our office? Briefly explain any current eye problems.

- ___ Routine exam - no particular problems Referred by my physician
- ___ Referred by my physician _____
- ___ Possible medical or surgical problem _____
- ___ Considering contact lenses _____
- ___ Other _____

Please check any of these eye problems you have had in the past.

- ___ Glaucoma ___ Muscle Imbalance ___ Retinal Problems ___ Eye Injuries ___ Cataracts ___ Infections
- ___ Double Vision ___ Blurred or Fuzzy Vision ___ Spots ___ Halos ___ Other

Explain any check mark _____

Have you ever had any of the following?

- ___ Tuberculosis ___ Sinus Infections ___ Do you smoke? ___ Allergies ___ Diabetes ___ Hay Fever
- ___ Skin Disorder(s) ___ Surgery ___ High Blood Pressure ___ Headaches ___ Bleeding Tendency
- ___ Cancer ___ Heart Trouble ___ Thyroid Trouble ___ Asthma ___ AIDS ___ HIV Infection
- ___ Now Pregnant ___ On Oral Contraceptives ___ Other

Explain any check mark _____

Family History. Please check if any of the following conditions are in your family.

- ___ Glaucoma ___ Strabismus (Cross Eyes) ___ Retinal Problems ___ Cataracts ___ Blindness
- ___ Diabetes ___ Other

Explain any check mark _____

Please check if you are currently having any of the following eye problems:

- ___ Pain, itching, burning or scratching sensation ___ Redness ___ Tearing or discharge
- ___ Blurred or fuzzy vision ___ Flashing lights ___ Problems with glasses
- ___ Cobwebs, dark spots or dark veils over vision ___ Other

Explain any check mark _____

Are you taking any medications? Please specify.

Are you allergic to any medications? Please specify.

Please list any operations or injuries you have had and when they occurred.

Date of your last eye exam _____ Who performed the exam? _____

How old are your glasses for reading? _____ Have you worn glasses in the past? YES NO

Do you wish to have your glasses changed? YES NO

Do you wear contact Lenses? YES NO If so: HARD SOFT Type, if known: _____

If yes, how long have you worn contacts? _____ How many hours per day? _____

If no, have you ever worn contacts? YES NO