Laurel Eye Physicians
14201 Laurel Park Drive, Suite 208
Laurel, MD 20707
PH: 301-498-6616 FAX: 301-329-2501

PATIENT REGISTRATION		
Last Name:	First Name:	Prefix: Mr. Mrs. Ms. Dr.
DOB:		Gender: Male Female
Address:		
City:	State:	Zip:
Home #:	Cell #:	Work #:
Email address:		
Preferred Method of Contact (circle one): Home Cell Work Email		
Emergency Contact Name:	Relationship:	Best Phone:

PATIENT INFORMATION				
Marital Status (Circle): Single	Married	Divorced	Widowed	Life Partner
Preferred Language:	Ethnicity:	Race:		

RESPONSIBLE PARTY ( ) SAME AS ABOVE		
Last Name:	First Name:	Prefix: Mr. Mrs. Ms. Dr.
DOB:	SS#:	Gender: Male Female
Address:		Phone:

PHYSICIANS' INFORMATION	
Primary Care Physician:	Phone:
Referring Physician:	Phone:
Other Physician:	Phone:
Pharmacy:	Phone:

I authorize payment of the insurance benefits (including Medicare Part B) to be made directly to Laurel Eye Physicians. I authorize Laurel Eye Physicians to release any information needed to process this claim.

Signature:_____ Date:_____

Reason for todays visit?

OCULAR HISTORY (NONE)	
Do you wear glasses?	Do you wear contacts?
Are you happy with your current glasses?	Contact Lens Brand?
How long have you been wearing glasses?	BC_____ Power: R_____ L_____
Eye conditions, surgeries or injuries? (circle and add date/year) Cataract Surgery Lasik Surgery Retina Surgery Glaucoma surgery Other issues?	
When and where was your last eye appointment? Were your eyes dilated at that visit? Do you see a Retina specialist? YES/NO Name? Do you see a Glaucoma specialist? YES/NO Name:	

FAMILY HISTORY of OCULAR ILLNESSES (NONE) (Adopted)
Glaucoma Relationship_____ Macular Degeneration Relationship_____ Blindness Relationship_____ Other Eye Disease _____

Ocular Medications you are allergic to: (NONE)

OCULAR MEDICATION LIST (NONE)			
NAME OF MEDICINE	REASON FOR TAKING	WHICH EYE	TIMES PER DAY

MEDICAL HISTORY (please circle all that apply) (NONE)		
Allergies	Depression	HIV/AIDS
Anxiety	Headaches/ Migraines	Seizures/Epilepsy
Arthritis (Osteo or Rheumatoid)	High Cholesterol	Stroke
Asthma or COPD	High Blood Pressure	Thyroid Disease
Blood Clots	Heart Disease or Heart Attack	Cancer (type)
Diabetes Are you using insulin? When were you diagnosed?	Sleep Apnea CPAP OR BIPAP Nightly / Sometimes / Never	Other Illnesses not listed:

YEAR	SURGERIES/HOSPITALIZATIONS

FAMILY HISTORY of MEDICAL ILLNESSES (NONE)	
Arthritis	Relationship_____
Diabetes	Relationship_____
Cancer	Relationship_____
High Blood Pressure	Relationship_____
Migraines	Relationship_____
Other ?	

PLEASE LIST ANY ALLERGIES (NONE)	
ALLERGY	REACTION

SOCIAL HISTORY			
What is/was your occupation?			Are you retired?
Do you smoke?	YES	How many cigarettes a day?_____	NO
	Formerly	How many years did you smoke?_____	
Do you drink alcohol?	YES	How many? _____day _____ week _____ month _____year	NO
Do you drive?	YES	Daytime Nighttime	NO

ALL OTHER MEDICATIONS, VITAMINS AND SUPPLEMENTS (NONE)			
Name of Medication	**Dose**	**Times per day**	**Reason for taking**

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OUR FINANCIAL POLICY

We are committed to providing you with the highest level of service and quality care. If you have medical insurance, we will strive to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our financial policy. Ultimately, however, any and all financial liability rests with the patient.

Our office participates with most major insurance plans. We provide medical ophthalmologic care to our patients and routine eye exams. We do not participate with most vision plans (VSP/DAVIS VISON, etc...). A refractive examination (measurement for glasses prescription) is NOT a covered service by most insurance companies, including Medicare. If you receive a prescription for glasses, you will be charged a $65.00 fee which is paid at the time of the visit. All contact lens visits and purchases must be paid at the time of service.

If you have a managed care plan that requires a referral to see a specialist, you must obtain a referral in order for your visit to be covered under your medical insurance. If you do not have a valid referral and still wish to be seen, you will be asked to pay for the visit prior to your examination.

It is the patient's/parents'/guardians' responsibility to:

- Be familiar with the benefits of your plan, including co-payments, co-insurance and deductibles.
- Bring ALL of your current insurance cards to all visits.
- Provide our office with current information including address, phone number and employer. In accordance with your insurance contract, you must be prepared to pay your co-payment at each visit. If you do not make your co-payment at the time of your visit, you will be charged an additional $10 fee. Any deductibles owing on your insurance will also be collected at the time of service. We accept cash, checks, and most major credit cards for services.

We appreciate prompt payment in full for any outstanding balance. If your account is turned over to our collection agency, you agree to pay any fees imposed by the collection agency in order to collect the overdue amount. Any check payments that do not clear the bank will be subject to a $60.00 returned check fee.

For all services rendered to minor (under the age of 18) patients, we will look to the adult accompanying the patient and/or the parent or guardian with whom the child resides for payment. In case of separation or divorce, when presenting insurance cards for the dependent enrolled under a subscriber other than you, please be prepared to supply their name, address, phone number, date of birth, and social security number. We request that you inform the subscriber that their insurance has been used.

We ask for at least a 24 hours notice if you need to cancel or reschedule your appointment. We charge a $65.00 fee IF you do NOT show up for your appointment or do NOT provide appropriate notice.

Legitimate emergencies will be taken into consideration.

Print Name

Signature Date

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Patient Authorization

I agree to accept legal responsibility and to promptly pay all charges when billed for my services. This includes co-pays, deductibles, co-insurance and non-covered services.

I certify that the information I have given with regard to my insurance is correct.

I authorize the release of any necessary information, including medical information for this or any related claim to the named billing agent and/or insurance company.

I permit a copy of this authorization to be used in place of the original.

I hereby authorize Laurel Eye Physicians to apply for benefits on my behalf for covered services rendered.

I request that payment from my insurance carrier(s) be made directly to Laurel Eye Physicians.

I have received a copy of the practices "Notice of Privacy Practices" which provides a detailed description of how my Personal Health Information used and disclosed.

PLEASE NOTE: IT IS YOUR RESPONSIBILITY TO BRING YOUR INSURANCE CARD(S) TO EVERY VISIT, A REFERRAL (FROM YOUR PRIMARY CARE PHYSICIAN) IF NECESSARY AND TO PAY YOUR CO-PAY AT THE TIME OF SERVICE IF REQUIRED.

Print Name

Signature **Dat e**

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Patient Acknowledgement Regarding Dilation and Contact Lens Exams

Precautions Following Dilation

It may be necessary to dilate your eyes during your exam or treatment. Dilation results in sensitivity to light and inability to see well both up close and distance for a few hours. We provide you with a free pair of disposable sunglasses or sunglass inserts for your convenience. Patients should wear sunglasses and be cautious walking and going up/down stairs.
We recommend avoiding driving or operating dangerous machinery immediately afterwards.

I have fully read and understand the above:

Print name _____

Signature _____ **Date** _____

Contact Lens Exam and Fee

If you wear contacts and would like a contact lens exam, please let our staff know. The exam is a separate appointment from your "regular medical" exam and is an out-of-pocket expense. Our professional staff will evaluate your current contact prescription and determine their current status. The fee for this service is NOT covered by your health insurance and will be collected at the time of service. We WILL NOT submit a claim to your Vision Plan. If you are interested in a Contact Lens Exam, please speak to our staff regarding scheduling an appointment and our pricing.

Any co-payment, co-insurance or deductibles you may have are SEPARATE from- and DO NOT include – the Contact Lens Exam Fee.

I have fully read the above and accept FULL financial responsibility for the exam, if provided.

Print Name _____

Signature _____ **Date** _____

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AUTHORIZATION TO RELEASE HEALTH INFORMATION TO FAMILY/FRIENDS

To make it easier to discuss your medical care with those that help you, we ask that you complete this form. It is **NOT** necessary for you to give us permission to provide medical information to your doctors.
Who would need permission for us to talk to in regards to you: e.g. Spouse/Partner, Children, Parents, Grandparents, Siblings, Aunts/Uncles, friends, etc.....

I authorize:

Name:_____

Relationship:_____Phone#_____

Name:_____

Relationship:_____Phone#_____

Name_____

Relationship:_____Phone#_____

Name_____

Relationship:_____Phone#_____

_____
Patients Name

_____
Signature Date