Dr. Marlan Anderson, Dr. Richard Bell, Dr. Edward Carl Elder, Dr. Kenneth Pierson
& Associates
Therapeutic Optometrists, Optometric Glaucoma Specialists

PATIENT REGISTRATION AND HEALTH HISTORY FORM

Date ___________

Patient Name ______________________________ **DOB**_____/_____/_____ **M / F**

Best contact # _________________ ☐ **Cell** ☐ **Home** ☐ **Work** **May we text you alerts:** ☐ **Yes** ☐ **No**

Alternate Phone # _______________ ☐ **Cell** ☐ **Home** ☐ **Work**

Mailing Address ______________________________
City State Zip

Social Security # _________________ **E-mail address** _________________

Employer _________________ **Occupation**_________________ **Grade if student** ______ **School** _______________

INSURANCE
Primary Member______________________________ **DOB**_____________ **Social Security #** __________________

Vision Plan: _______________ **ID #**______________________________

Medical Insurance: ______________ **ID #**__________________________ **Group #**___________________

I would like an eye examination for: ☐ **glasses** ☐ **contact lenses**

Date of last eye exam _____________ **Dr:** _________________

Are you pregnant at this time? ________ **How long?** _______

Check any health and ocular conditions

You	Family		You	Family	
☐	☐	**Diabetes**	☐	☐	**Cataracts**
☐	☐	**Hypertension**	☐	☐	**Glaucoma**
☐	☐	**High cholesterol**	☐	☐	**Macular degeneration**
☐	☐	**Thyroid disease**	☐	☐	**Blindness**
☐	☐	**Arthritis**	☐		**Lazy eye**
☐	☐	**Asthma**	☐		**Eye surgery** type______________________
☐	☐	**Seasonal allergies**	☐		**Eye trauma** type______________________
☐	☐	**Cancer** type_______________	☐		**Other** ________________________________

List any medicines you are taking: ____

____

List any medicines you are allergic to: ____

Do you have a history of tobacco / alcohol or substance abuse? _______________

Do you ever experience any of the following eye health symptoms?

☐ **Dryness** ☐ **Itchy** ☐ **Burning** ☐ **Redness**
☐ **Eye strain** ☐ **Headaches** ☐ **Tired eyes** ☐ **Pain**
☐ **Flashes of light** ☐ **Light sensitivity** ☐ **Floaters** ☐ **Watery**
☐ **Other**_____________

(Please also complete the back side)

VISUAL FIELDS AND DILATION TESTING

The Doctors at Eyetx Vision Centers strongly recommend that all patients receive a visual field test and dilation as part of a comprehensive eye examination. These procedures **are included** in the eye examination benefits for **Aetna, BCBS, Eyemed, Medicare, Superior, Tricare, Vision Service Plan (VSP).**

IF YOUR INSURANCE IS NOT LISTED, PLEASE ASK AN EYETX EMPLOYEE FOR ASSISTANCE

Visual Fields: $15.00

Visual field testing can assist us in early detection of glaucoma, retinal disease, some neurological disease (such as brain tumors and optic nerve disease) and to better enable us to diagnose causes of headaches.

Dilation: $15.00

The dilation allows us a better view of the back of the eye. While routine dilation of the eyes is recommended at least every two years, if you have a condition such as diabetes, high blood pressure, cataracts, headaches, high myopia (nearsightedness), symptoms of flashes of lights, floaters, glaucoma, or a family history of glaucoma, you are strongly urged to have your pupils dilated today.

Is it okay to dilate your eyes? ☐ Yes ☐ Reschedule ☐ Decline
Is it okay to perform Visual Field test? ☐ Yes ☐ Reschedule ☐ Decline

By declining you release the Doctors of Eyetx vision centers from any liabilities related to the failure to diagnose or treat any eye condition due to the lack of diagnostic information which could have been obtained by these tests.

Payment Policy (please **initial** to show you have read)

____Payment is expected at the time services are rendered. Contact lenses require payment prior to ordering. Glasses require full payment prior to dispensing.

____Uncollected fees whether from insurance, insufficient funds, check stop payment, credit card charge backs, etc... remain the responsibility of the patient. (Parent or legal guardian if a minor)

____When insurance benefits are verified, the information provided by the customer service representative is **NOT** a guarantee of payment.

____There may be additional fees for co-pays, deductibles and non-covered services after payment is received from the insurance company.

____You are financially responsible for any and all charges. In addition, you agree to pay all fees incurred to collect on your account if necessary. Unpaid balances accrue interest at the rate 1.5% monthly (18% APR).

Assignment of benefits (only applicable if we are filing with a vision or medical insurance for you)

____ I hereby authorize my insurance/medical benefits to be paid directly to Dr.'s Anderson, Bell, Elder, Pierson & any Associate Dr.

____ I further authorize release of any medical records or information necessary to process this claim.

______________________________ ______________________

Patient / Legal Guardian's signature **Date**

Acknowledgement of Notice of Privacy Policy

We keep a record of the care we give you. The record also contains other health information about you. We will **not** disclose your health information to others unless we have your permission to do so or unless the law allows or requires us to do so.

By signing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices, and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices and agree to its terms.

May we discuss your medical condition with any member of your family? Yes / No

If yes, please name the members allowed: 1) ______________________________ 2) ______________________________

______________________________ ______________________

Patient **Date**

If you are signing as a personal representative of the patient please indicate your relationship.

______________________________ ______________________

Representative **Relationship to patient**

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

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