

# MONTGOMERY EYE PHYSICIANS & SURGEONS

## PATIENT REGISTRATION FORM

Account #:

Dr.  Mrs.  
Name:  Mr.  Ms. \_\_\_\_\_  
LAST FIRST M.I.

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Social Security: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Sex:  Male  Female

Address: \_\_\_\_\_  
STREET Apt./Unit #

CITY STATE ZIP CODE

Cell: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ E-mail: \_\_\_\_\_ @ \_\_\_\_\_

Home: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Work: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Preferred:  Cell  Home  Work

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Pharmacy Phone #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

City/Intersection: \_\_\_\_\_

I agree that Montgomery Eye Physicians & Surgeons, PC may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payers for treatment purposes.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Contact Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Previous Eye Doctor and last eye exam: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone#: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Referring Doctor: \_\_\_\_\_ Phone#: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

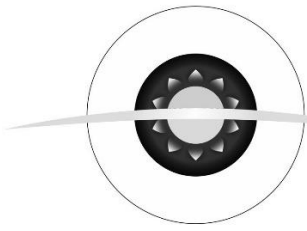
Do you have any of the following doctors whom you visit?  Check here if NO

Please list name and phone number:

Endocrinologist: \_\_\_\_\_ Phone#: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Cardiologist: \_\_\_\_\_ Phone#: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Other Doctor(s): \_\_\_\_\_ Phone#: (\_\_\_\_) \_\_\_\_ - \_\_\_\_



# MONTGOMERY EYE PHYSICIANS & SURGEONS

## INSURANCE INFORMATION

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### Primary Medical Insurance

Insurance Company Name: \_\_\_\_\_

Policy/Member I.D. #: \_\_\_\_\_ Group #: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

(if other than self)

Relationship to insured  Spouse  Dependent  Other \_\_\_\_\_

### Secondary Medical Insurance

Insurance Company Name: \_\_\_\_\_

Policy/Member I.D. #: \_\_\_\_\_ Group #: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

(if other than self)

Relationship to insured  Spouse  Dependent  Other \_\_\_\_\_

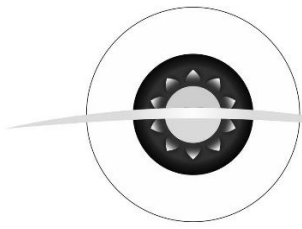
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### Patient Agreement

I understand that payment is due at the time of service. I certify that the information provided on this form is correct. I authorize the release of information including medical information to this organization and all insurance organizations involved with my care.

Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_



# MONTGOMERY EYE PHYSICIANS & SURGEONS

## OFFICE POLICY & FINANCIAL RESPONSIBILITIES Account #:

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As the patient it is your responsibility to provide your accurate medical insurance information. Please have your photo identification and insurance information available at your visit to ensure that your claim can be processed correctly.

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### **APPOINTMENTS:**

We request that you keep scheduled appointments and arrive at the scheduled time. If you are unable to keep your appointment, please give at least 24 hours' notice so that we may offer that time to another patient. Cancellations of less than 24 hours prior to your appointment, or a No-Show for your appointment, will result in a **\$50.00** fee.

If you are late to your scheduled appointment, we will make every effort to accommodate you. However, we may need to reschedule your appointment.

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Patient Initials

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### **INSURANCES & PATIENT PAYMENTS:**

Your claim will be submitted to the insurance that we have on file. It is your responsibility to submit all relevant medical insurance information to us and update it as it becomes necessary. We have no control over how your insurance company processes its claims or if and how much they may pay on a claim. You are ultimately responsible for knowing your benefits and the terms of your coverage. Any amount that is not covered by your insurance is your financial responsibility and you will be billed accordingly.

**Copay and any self-pay fees** are due at the time of service. If these are not paid before leaving the office, we reserve the right to add an administrative charge of **\$10.00** to your account in order to defray the cost of obtaining the copay/fees.

Unfortunately, we DO NOT participate with vision insurance plans. We can check/dispense a glasses prescription (**refraction**) for you and submit the claim to your medical insurance. However, Medicare and most commercial insurances do not cover this fee. Payment for a refraction is due at the time of service unless we have evidence that your insurance has paid in the past.

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Patient Initials

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## OFFICE POLICY & FINANCIAL RESPONSIBILITIES continued

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### ACCOUNT BALANCES:

Any balances that extend beyond 60 days will be assessed a service charge of **\$20.00**. In the event that this balance should be submitted to a collection agency, a collection fee (30% of the outstanding balance) will be charged to the account. The collection agency will report any unpaid balance to the major credit card bureaus. If for any reason, the account is litigated, you will also be held accountable for all attorney costs and court fees. Fees are subject to change; in that event, you will be notified of such changes.

\_\_\_\_\_  
Patient Initials

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### RETURNED CHECKS:

Any payment made by check that does not clear your bank account will result in a fee for insufficient funds. Our fee is **\$30.00** and will be added to your account for each returned check.

\_\_\_\_\_  
Patient Initials

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### REFERRALS:

If your insurance plan requires a referral, it must be presented before seeing the physician. If you do not have the required referral, we reserve the right to reschedule your appointment.

\_\_\_\_\_  
Patient Initials

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### FORMS:

There is a **\$25** fee for any forms that need to be completed by the office. MVA or driver's license renewal forms will be waived if completed at the time of your appointment.

\_\_\_\_\_  
Patient Initials

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The physicians and staff at Montgomery Eye Physicians & Surgeons appreciate your confidence in allowing us to participate in your eye care.

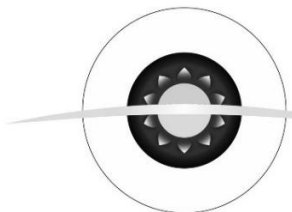
Your signature indicates that you have read, understand and agree to our office policy & financial responsibilities of our office.

\_\_\_\_\_  
Printed name of patient or patients representative

\_\_\_\_\_  
Signature of patient or patients representative

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to patient



# MONTGOMERY EYE PHYSICIANS & SURGEONS

## Current Medications (prescription & over the counter)

Please fill out in its entirety OR provide a list of your medications  check here if NONE

Medication Name	Strength/Dose	How often

## Current EYE Medications (prescription & over the counter) check here if NONE

Medication Name	Strength	How often	Which Eye

**Allergies: List any allergies or adverse reactions to medications or other substances – please list drug name and reaction:**  check here if no allergies

Name of Drug/Substance	Allergic Reaction

**PAST SURGICAL HISTORY (list all past surgeries):**  check here if NONE

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**PERSONAL MEDICAL HISTORY (check all that apply):**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> NONE                | <input type="checkbox"/> Blood Disorder       | <input type="checkbox"/> Depression/Anxiety                       |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Arthritis (Joints)   | <input type="checkbox"/> Kidney Disease                           |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Asthma               | Dialysis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> High Cholesterol    | <input type="checkbox"/> COPD                 | Cancer:   |
| <input type="checkbox"/> Thyroid Disease     | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Breast <input type="checkbox"/> Lung     |
| <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Migraine             | <input type="checkbox"/> Prostate <input type="checkbox"/> Colon  |
| <input type="checkbox"/> Stroke              | <input type="checkbox"/> Seasonal Allergies   | <input type="checkbox"/> Thyroid <input type="checkbox"/> Skin    |
| <input type="checkbox"/> Other: _____        | <input type="checkbox"/> Heart Attack         | <input type="checkbox"/> Other: _____                             |

**PERSONAL EYE HISTORY: check here if NONE**

- |   |  |
|---|--|
| <input type="checkbox"/> Cataracts            | <input type="checkbox"/> Retinal Tear/Detachment |
| <input type="checkbox"/> Dry Eyes             | <input type="checkbox"/> Retinal Tear            |
| <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Macular Degeneration    |
| <input type="checkbox"/> Diabetic Retinopathy | <input type="checkbox"/> Other: _____            |

List all past eye surgeries, eye injections &/or eye laser treatments: \_\_\_\_\_

Have you gone to see any of the following in the past 2 years?

Retina Specialist:  No  Yes → \_\_\_\_\_  
(Name and address/Phone number)

Optometrist:  No  Yes → \_\_\_\_\_  
(Name and address/Phone number)

Other Eye Specialist: \_\_\_\_\_

**FAMILY HISTORY:**

	Yes	No	Relationship to patient
Glaucoma			
Macular Degeneration			
Blindness			
Diabetes			
Cancer			
Hypertension			
Heart Disease			
Other:			

**SOCIAL HISTORY:**

Do you currently smoke?  No  Yes → How many packs per day? \_\_\_\_\_

Do you have a history of smoking?  No  Yes → When did you quit? \_\_\_\_\_  
(Month/Year)

Do you drink alcohol?  No  Yes → How often:  Daily  Occasional