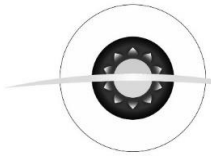

MONTGOMERY EYE
PHYSICIANS & SURGEONS

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: (____) ____-____ Home: (____) ____-____ Preferred: ☐ Cell ☐ Home ☐ Work

E-mail: _____

Employer: _____ Work: (____) ____-____

Emergency Contact: _____ Relationship: _____

Contact Phone: (____) ____-____ Other Contact: _____

Primary Care Physician: _____ Phone#: (____) ____-____

Referring Doctor: _____ Phone#: (____) ____-____

Do you have any of the following doctors whom you visit? ☐ **NO**

Please list name and phone number:

☐ Endocrinologist: _____ Phone#: (____) ____-____

☐ Cardiologist: _____ Phone#: (____) ____-____

☐ Other Doctor(s): _____ Phone#: (____) ____-____

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: _____

CONTINUED ON NEXT PAGE →

INSURANCE INFORMATION

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_____

MEPS does not participate with any Vision insurance plans

(i.e. Davis, NVA, Spectra, EyeMed, etc.)

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:___/___/___

CONTINUED ON NEXT PAGE →

MONTGOMERY EYE PHYSICIANS & SURGEONS
OFFICE POLICY & FINANCIAL RESPONSIBILITIES
(Read through thoroughly)

Patient Name:

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.

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.

Patient Initials

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.

Patient Initials

CONTINUED ON NEXT PAGE →

MONTGOMERY EYE PHYSICIANS & SURGEONS
OFFICE POLICY & FINANCIAL RESPONSIBILITIES continued

ACCOUNT BALANCES:

Any balances that are past due 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

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

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

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

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 patient's representative

_____ _____ / _____ / _____
Signature of patient or patients representative Date

_____
Relationship to patient

CONTINUED ON NEXT PAGE →

Current Medications (prescription & over the counter) ❑ NONE

Please fill out in its entirety OR provide a list of your medications

Medication Name	Strength/Dose	How often

Current EYE Medications (prescription & over the counter) ❑ NONE

Medication Name	Strength	How often	Which Eye

PERSONAL EYE HISTORY: ❑ NONE

❑ Cataracts
❑ Dry Eyes
❑ Glaucoma
❑ Diabetic Retinopathy
❑ Retinal Tear/Detachment
❑ Retinal Tear
❑ Macular Degeneration
❑ 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:_____

Pharmacy Name:_____ Pharmacy Phone #:(____) ____-____

City/Intersection:_____

PERSONAL MEDICAL HISTORY (check all that apply):

❑ NONE
❑ Diabetes
❑ High Blood Pressure
❑ High Cholesterol
❑ Thyroid Disease
❑ Heart Disease
❑ Stroke
❑ Other:_____

❑ Blood Disorder
❑ Arthritis (Joints)
❑ Asthma
❑ COPD
❑ Rheumatoid Arthritis
❑ Migraine
❑ Seasonal Allergies
❑ Heart Attack

❑ Depression
❑ Anxiety
❑ Kidney Disease
Dialysis ❑Yes ❑No
Cancer:
❑ Breast ❑ Lung
❑ Prostate ❑ Colon
❑ Thyroid ❑ Skin
❑ Other:_____

PAST SURGICAL HISTORY (list all past surgeries): ❑ NONE

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	Reaction

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?_____

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

Your occupation:_____ ❑ Retired ❑ Disabled