



Beach Eye Medical Group REGISTRATION AND MEDICAL HISTORY

1

PATIENT INFORMATION

Patient _____
 Address _____

 City/State/Zip _____
 Home Phone () _____ Other () _____
 Work Phone () _____ ext. _____
 Age _____ Birth date _____
 Sex M F Email: _____
 Single Married Widowed Separated Divorced
 Employer _____
 Employer Phone _____
 Spouse's Name _____
 Primary Care Physician _____
 Whom may we thank for referring you?

2

INSURANCE

Person responsible for account? _____
 Relationship to Patient _____
 Insurance Co _____
 Subscriber's Name _____
 Birth Date _____
 Subscriber ID _____ Group#: _____

CONFIDENTIALITY & BENEFITS: ASSIGNMENT & RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage and assign directly to Beach Eye Medical Group. all insurance benefits to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that my records are confidential and my signature authorizes the doctor to release all information necessary for the purpose of health care, insurance operations and to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____
 Relationship _____ Date _____

EMERGENCY CONTACT (Please specify someone who does not live in your household)

Name _____ Relationship _____
 Home Phone _____ Work Phone _____

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NEW PATIENT EYE HEALTH HISTORY

<p>Eye Doctor _____ Date of Last Visit _____ Date of Last Eye Exam _____</p> <p>Do You Wear Glasses? <input type="radio"/> Not at all <input type="radio"/> All the time <input type="radio"/> Occasionally <input type="radio"/> Reading <input type="radio"/> Driving <input type="radio"/> TV <input type="radio"/> _____</p> <p>Do You Wear Contact Lenses? <input type="radio"/> Never <input type="radio"/> Not any more <input type="radio"/> Occasionally Type _____ Hrs/Day _____ Describe any problems you have with your contacts: _____ List any and all eye surgeries (including lasers): _____</p>	<p>Check to indicate if you have had any of the following:</p> <table border="0" style="width: 100%;"> <tr> <td><input type="radio"/> Blindness</td> <td><input type="radio"/> Dry Eyes</td> <td><input type="radio"/> Macular Degeneration</td> </tr> <tr> <td><input type="radio"/> Bloodshot Eyes</td> <td><input type="radio"/> Eye Infection</td> <td><input type="radio"/> Migraine Headaches</td> </tr> <tr> <td><input type="radio"/> Blurred Vision, Distance</td> <td><input type="radio"/> Eye Injury</td> <td><input type="radio"/> Night Vision, Poor</td> </tr> <tr> <td><input type="radio"/> Blurred Vision, Near</td> <td><input type="radio"/> Eye Strain</td> <td><input type="radio"/> Red Eyes</td> </tr> <tr> <td><input type="radio"/> Burning Eyes</td> <td><input type="radio"/> Fainting Spells/Blackouts</td> <td><input type="radio"/> Retinal Detachment</td> </tr> <tr> <td><input type="radio"/> Cataracts</td> <td><input type="radio"/> Floaters or spots</td> <td><input type="radio"/> Seeing Halos</td> </tr> <tr> <td><input type="radio"/> Color Vision – Poor</td> <td><input type="radio"/> Glaucoma</td> <td><input type="radio"/> Seeing Flashes</td> </tr> <tr> <td><input type="radio"/> Crossed Eyes</td> <td><input type="radio"/> Headaches</td> <td><input type="radio"/> Temporary Vision Loss</td> </tr> <tr> <td><input type="radio"/> Discharge from Eyes</td> <td><input type="radio"/> Itching Eyes</td> <td><input type="radio"/> Turned Eye</td> </tr> <tr> <td><input type="radio"/> Dizzy Spells</td> <td><input type="radio"/> Lazy Eyes</td> <td><input type="radio"/> Twitching Eyelid</td> </tr> <tr> <td><input type="radio"/> Double Vision</td> <td><input type="radio"/> Loss of Vision</td> <td><input type="radio"/> Watering Eyes</td> </tr> <tr> <td><input type="radio"/> Other _____</td> <td></td> <td></td> </tr> </table>	<input type="radio"/> Blindness	<input type="radio"/> Dry Eyes	<input type="radio"/> Macular Degeneration	<input type="radio"/> Bloodshot Eyes	<input type="radio"/> Eye Infection	<input type="radio"/> Migraine Headaches	<input type="radio"/> Blurred Vision, Distance	<input type="radio"/> Eye Injury	<input type="radio"/> Night Vision, Poor	<input type="radio"/> Blurred Vision, Near	<input type="radio"/> Eye Strain	<input type="radio"/> Red Eyes	<input type="radio"/> Burning Eyes	<input type="radio"/> Fainting Spells/Blackouts	<input type="radio"/> Retinal Detachment	<input type="radio"/> Cataracts	<input type="radio"/> Floaters or spots	<input type="radio"/> Seeing Halos	<input type="radio"/> Color Vision – Poor	<input type="radio"/> Glaucoma	<input type="radio"/> Seeing Flashes	<input type="radio"/> Crossed Eyes	<input type="radio"/> Headaches	<input type="radio"/> Temporary Vision Loss	<input type="radio"/> Discharge from Eyes	<input type="radio"/> Itching Eyes	<input type="radio"/> Turned Eye	<input type="radio"/> Dizzy Spells	<input type="radio"/> Lazy Eyes	<input type="radio"/> Twitching Eyelid	<input type="radio"/> Double Vision	<input type="radio"/> Loss of Vision	<input type="radio"/> Watering Eyes	<input type="radio"/> Other _____		
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INFORMATION REGARDING DILATING EYE DROPS

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye. Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it's best if you make arrangements not to drive yourself.

Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize Beach Eye Medical Group to administer dilating eye drops if necessary. I understand I have the opportunity to use sunglasses provided by Beach Eye Medical Group after my office visit.

 Patient (or person authorized to sign for patient) Date

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HEALTH HISTORY

Check Box to indicate if you have had any of the following:

- AIDS HIV
- Arthritis
- Artificial Heart Valve
- Artificial Joints
- Asthma
- Bleeding
- Cancer
- Chemical Dependency
- Diabetes
- Drug Sensitivity
- Emphysema
- Epilepsy
- Hay Fever
- Heart Condition
- Hepatitis (Type _____)
- High Blood Pressure
- Kidney Disease
- Lupus
- Migraine Headaches
- Pacemaker
- Rheumatic Fever
- Shingles
- Skin Condition
- Stroke
- Thyroid Conditions
- Tuberculosis

Other Medical Problems (not listed already)

Check if a blood relative has had any of the following:

- Blindness _____
- Cataracts _____
- Diabetes _____
- Glaucoma _____
- Retinal Detachment _____

Relationship to you

Past Surgical History (except eye)

Personal/Social History

Are You Pregnant? _____ Number of Children _____

Tobacco Use _____ Alcohol Use _____

NO CHANGE SINCE _____ INITIAL _____

MEDICATIONS

List medications you are currently taking, including eye drops:

- No Medications
 - Taking Aspirin
-
-
-

NO CHANGE SINCE _____ INITIAL _____

Phone: (_____)

Pharmacy Name _____

ALLERGIES

List your allergies to medications or other substances:

NO CHANGE SINCE _____ INITIAL _____

NO ALLERGIES

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INSURANCE AUTHORIZATION

I request that payment of authorized Medicare benefits be made to me or on my behalf to Beach Eye Medical Group for any services furnished me by their doctor. I authorize any holder of medical information about me to release to Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer of agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier. As per office policy a fee of \$50 will be made to your account for all checks returned from the bank. Thank you for allowing us to take care of your eyes.

By Signing this, I _____, acknowledge my financial responsibility as described above and (Patient Name / Person Financially Responsible) have provided the above information today.