

MACHA FAMILY EYE CARE- Registration Form

Welcome To Our Office!

Date ____/____/____

Please circle appropriate title: (Mr. /Mrs./ Miss/ Ms./ Dr./ Rev.)

Name: Last _____ First _____ MI _____ Nickname _____

Address _____ City _____ State _____ Zip _____

Phone (Home) (____) _____ (Work) (____) _____ (Cell) (____) _____

E-mail _____ Sex: (Male/Female) Date of Birth ____/____/____ Age _____

Social Security # ____/____/____ Marital Status: (Single/Married/Divorced/Widowed)

Employed: (Full-time / Part-time / Unemployed / Full-time Student)

Employer _____ Occupation: _____

Referred by: Phone Book __ Insurance Book__ Drive By__ Family__ Friend __ Name: _____

Guarantor Information:

Name: _____ Address/City: _____ Zip: _____

Phone: (Home:(____) _____ Work:(____) _____ Social Security # ____/____/____

Employer: _____ Sex: (Male/Female) Date of Birth ____/____/____ Relationship: _____

Primary Vision Insurance:

Company Name:(VSP/ VCP/DAVIS/EYEMED/SPECTERA) or Other: _____

Policy Holder Name: _____ Soc. Sec. # ____/____/____

Secondary Vision Insurance:

Company Name:(VSP/ VCP/DAVIS/EYEMED/SPECTERA) or Other: _____

Policy Holder Name: _____ Soc. Sec. # ____/____/____

Primary Medical Insurance:

Company Name: (Medicare / Medicaid / Anthem /Aetna / United Healthcare) or Other: _____

Policy Holder Name: _____ Soc. Sec. # ____/____/____ Policy # : _____ Group #: _____

Secondary Medical Insurance:

Company Name: (Medicare / Medicaid / Anthem /Aetna / United Healthcare) or Other: _____

Policy Holder Name: _____ Soc. Sec. # ____/____/____ Policy # : _____ Group #: _____

In Case of Emergency, Contact: _____ Relationship _____

Address _____ Phone # _____

Please Turn Page Over

Patient Name: _____ Date: _____

FINANCIAL POLICIES

Co-payments and fees not covered by your insurance are due upon date of service. We will file claims for services rendered to the appropriate insurance payer in good faith. All medical eyecare is subject to any insurance deductible. It is the patient's responsibility to know the specifics of the insurance plan and to pay any amounts applied to the patient's deductible and/or co-insurance. A minimum **50% Down Payment** on custom and special order materials is required to start our order. Any balance will be due upon dispensing of your eyewear. Unpaid balances are subject to monthly late fees and additional service fees if sent to collections. **No cash refund on materials.**

INSURANCE AUTHORIZATION

I have read and understood the above policies and authorize payment of insurance benefits from Medicare, Medigap, or other insurance companies to be made on my behalf for any optometric services rendered to Macha Family Eye Care, PC. I also authorize Macha Family Eye Care, PC to release any information needed to the appropriate agency to determine any benefits and provide appropriate care.

Signature (Responsible Party): _____ Date: ____/____/____

Printed Name of Responsible Party: _____

NOTICE OF PRIVACY POLICIES

By Signing below, I indicate that I have received a copy of Macha Family Eye Care's Notice of Privacy Practices.

Signature (Responsible Party): _____ Date: ____/____/____

Printed Name of Responsible Party: _____

Patient Name: _____ Date: _____

COMPREHENSIVE MEDICAL HISTORY

Reason for your visit today: Routine Eye Exam Medical Visit Follow-up Fit/Dispense Contacts Other: _____

Date of Last Eye Exam: ____/____/____ Date of Last Medical Exam: ____/____/____

Primary Care Physician (PCP) Name: _____ Address: _____

Are you interested in being fit (if necessary) for: Eyeglasses Contacts or Both

Do you currently wear: Eyeglasses Contacts or Both Do you sleep in contacts? Yes No

Are you currently experiencing difficulties with your eyes or your vision? No Yes If yes, Please explain: _____

Do you use the computer at home or work? No Yes If yes, Please explain any computer related problems: _____

Are you interested in refractive surgery ? Yes No

List any eye conditions and surgeries you have had (including crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections): _____

List any eye medications you currently take: _____

List any other medications you take (including oral contraceptives, aspirin, over the counter medications): _____

Do you now or have you in the past used: Tobacco Y/N Alcohol Y/N Recreational drug use Y/N

Do you have seasonal allergies? No Yes If yes, please explain any problems: _____

Do you have any allergies to medications? No Yes If yes, explain: _____

List all major injuries, surgeries and/or hospitalizations you have had: _____

Are you pregnant and/or nursing? No Yes

Have you or anyone in your family been diagnosed with the following conditions:

Disease/Condition	No	Yes	?	Relationship To You
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
HIV/Aids/Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____