Beavercreek Vision Center

PATIENT REGISTRATION

PLEASE PRINT

PATIENT

FIRST NAME	M. I.	NICKNAME	LAST NAME	SEX	STUDENT
				M_____ F_____	Y_____ N_____

STREET ADDRESS	SOCIAL SECURITY NO.	AGE	DATE OF BIRTH (M M D D Y Y)

CITY	STATE	ZIP CODE	HOME PHONE ( )

E-MAIL ADDRESS

PATIENT'S RELATIONSHIP TO ENROLLEE	MARITAL STATUS	EMPLOYMENT	WORK PHONE ( )
Self_____ Spouse_____ Dependent/Child_____	Sing___Mar___Div___Wid___	FT___PT___Ret___Unem___	

NAME OF EMPLOYER / OCCUPATION	ADDRESS OF EMPLOYER

IS PATIENT COVERED BY ANOTHER GROUP VISION PLAN? VISION PLAN NAME UNION LOCAL GROUP# NAME AND ADDRESS OF CARRIER

___Yes ___No If "Yes", Complete the Following:

WAS AN ACCIDENT INVOLVED? ___Yes ___No If "Yes", Was the injured Person at Work When the Accident Happened? ___Yes ___No

HAS CATARACT SURGERY BEEN PERFORMED? ___Yes ___No If Yes: Date _____ Doctor: _____

Falsification or misrepresentation of information requested below may result in action(s) deemed appropriate by Employer and/or insurance.
(Please answer questions on Reverse side before claim is completed)

INSURANCE

FIRST NAME	MIDDLE INITIAL	LAST NAME	SOCIAL SECURITY NO.

STREET ADDRESS	AGE	DATE OF BIRTH (M M D D Y Y)	SEX
			M___ F___

CITY	STATE	ZIP CODE	

NAME OF EMPLOYER	ADDRESS OF EMPLOYER

AUTHORIZATION

I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for services to the physician OR organization furnishing the services and authorize such physician OR organization to submit a claim to my insurance carrier OR Medicare for payment. I authorize any holder of medical or other information about me to release to insurance carriers OR the Health Care Financing Administration and its agents OR the Social Security Administration or its intermediaries OR any agency, group or person(s) necessary to secure payment any information needed for this or related Medicare claim. *For and in consideration of services rendered and to be rendered by the above listed medical provider, I hereby guarantee payment of all charges incurred for this account. *The patient or his/her representative recognizing the need for health care, consents to the above listed medical provider rendering services as ordered by the physicians, including medical or surgical treatment, laboratory procedures, X-ray examinations or other services rendered under the general and specific instructions of the physicians. *I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct.

DATE_____ SIGNATURE X_____

PATIENT (PARENT/GUARDIAN IF MINOR)

Beavercreek Vision Center

Name: _____

Occupation: _____

Past Medical History and Review of Systems

YES	NO	(please give details for YES answers)
☐	☐	Currently pregnant or nursing
☐	☐	Autoimmune Disease (Lupus, Sarcoid, Wegener's, Fibromyalgia, Rheumatoid)
☐	☐	Infectious Disease (HIV, Hepatitis, TB)
☐	☐	Depression/Anxiety Disorders
☐	☐	Skin Disorders (specify below)
☐	☐	Arthritis (specify below)
☐	☐	Diabetes
☐	☐	High Blood Pressure
☐	☐	Heart Disease (specify below)
☐	☐	Strokes
☐	☐	Asthma or Lung Disease
☐	☐	Thyroid problems
☐	☐	Stomach or GI problems
☐	☐	Cancer (specify below)
☐	☐	Bone or muscle problems

List surgeries and specify from above:

Medicine Allergies? ☐ NONE

Medications? ☐ NONE	Dose (mg)	Times Daily

Medical History

Date: _____

Family Doctor: _____

Address: _____ Ph: _____

_____

Past Eye History and Surgery

YES	NO	(please give details for YES answers)
☐	☐	Eye Surgery/Lasers (specify below)
☐	☐	Cataracts
☐	☐	Glaucoma
☐	☐	Macular Degeneration
☐	☐	Retinal Detachments
☐	☐	Lazy Eye or Muscle Surgery
☐	☐	Eye inflammation (iritis, episcleritis)

List eye surgeries and specify others:

Eye Drops	Eye	Times Daily
%	☐ R / ☐ L	
%	☐ R / ☐ L	
%	☐ R / ☐ L	

What type of contacts do you wear?

☐ Soft ☐ Hard ☐ Don't wear them

...last had them in (now / _____ days ago)

Have you had past contact lens problems?

☐ No ☐ Yes ☐ Yes, and quit wearing them

Do you have a Family History of:

YES	NO	(please give details for YES answers)
☐	☐	Glaucoma
☐	☐	Macular Degeneration
☐	☐	Diabetes
☐	☐	Heart Disease or Strokes

Social History

Smoke now?	☐ never	☐ rarely	☐ daily
In the past?	☐ never	☐ rarely	☐ daily
Alcohol intake?	☐ never	☐ rarely	☐ daily