Patient Registration

Treasure Valley Eye Center

Welcome to our practice. In order to better serve you, please completely fill out the following information.
Dr. Miller, Dr. Williams, Dr. Crawford, Dr. Christensen thank you for allowing us to serve you.

Last Name_____ First Name_____ Middle Init_____

Name you prefer to be called_____ Date of Birth_____ Social Security #_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Daytime Phone_____ Cell Phone_____

Employment status: Full-Time Part-Time Student Retired (please circle one) Employer: _____

Occupation: _____

Martial Status: Single Married Divorced Widowed (please circle one)

Email address: _____

Financially Responsible Party Name (if different from above) _____ Date of Birth_____

Address _____ City_____ State_____ Zip_____

Home Phone_____ Relationship to patient _____

Family members you would like financially linked to your account:

Name: _____ Date of birth: _____

Name: _____ Date of birth: _____

Emergency Contact (friend or family not living with patient):

Name: _____ Relationship: _____

Phone #: _____

MEDICAL INSURANCE

Primary Medical Insurance Company: _____ ID #: _____

Policy Holder Name: Policy Holder Date of Birth: Group # _____

Secondary Medical Insurance Company: _____ ID #: _____

Policy Holder Name: Policy Holder Date of Birth: Group # _____

VISION INSURANCE

Do you have a **supplemental Vision Plan** as part of your insurance policy OR a SEPARATE **Vision-only** Policy? YES - NO DON'T KNOW

VSP EyeMed (please circle one) **Other:** _____ ID #: _____

Policy Holder Name: Policy Holder Date of Birth: Policy Holder Social Sec #:

Please provide copy of cards

In order for our office to more efficiently process medical and vision claims, please provide us with the above information

rev 01/15/15

How did you hear about us? (please check box)

- ☐ Referred by another doctor- who?_____
- ☐ Referred by a friend or family member - who?_____
- ☐ Insurance Co. Provider List ☐ Newspaper ☐ Radio ☐ Yellow Pages ☐ Mailer
- ☐ Noted clinic walking by - convenient location ☐ Other _____

Lifestyle and your vision: What activities or hobbies are important to you or in which you spend much of your time?

- ☐ Reading ☐ Sports - which ones? _____
- ☐ Computer work ☐ Outdoor activities - which ones? _____
- ☐ Driving ☐ Hobbies - which ones? _____
- ☐ School work ☐ Other - specify: _____

I, the undersigned, certify that I (or my dependent) have the above insurance benefits and assign directly to Treasure Valley Eye Center all insurance benefits payable to me for the services rendered. I understand that I am financially responsible for all charges whether paid for or not by insurance. I hereby authorize Treasure Valley Eye Center to release all information necessary about diagnoses and services rendered to secure the payment of benefits and authorize the use of this signature on all insurance submissions.

_____ _____

Signature of Responsible Party Date

Name _____ DOB _____

Referring Doctor _____ Primary Doctor _____

Social History

□ Smoke_____ pk/day

□ Drink _____ drinks /day /week /month

□ Occupation

_____

□ Married □ Single □ Divorced

_____

Do you live alone? □ Yes □ No

_____

Family History

□ Macular Degeneration

□ Glaucoma

□ Retinal Detachment

□ High Blood Pressure

□ Heart Disease

□ Diabetes

□ Other _____

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Medications

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Allergies

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Review of Systems

Constitutional
□ weight gain/loss
□ chronic fatigue
□ fever/chills

Ear/Nose/Throat
□ loss of hearing
□ sinus problems
□ swollen glands
□ nosebleeds

Allergy/Immunology
□ hay fever
□ environmental allergies

Gastrointestinal
□ nausea
□ vomiting
□ constipation
□ diarrhea
□ abdominal pain

Musculoskeletal
□ painful joints
□ rheumatoid arthritis
□ swollen joints

Neurological
□ numbness/weakness
□ loss of memory
□ dizziness
□ slurred speech
□ headache

Respiratory
□ shortness of breath
□ wheezing
□ cough
□ asthma
□ lung disease

Hematological
□ easy bruising
□ anemia
□ low blood count

Urinary
□ painful urination
□ incontinence
□ difficult urination

Heart/Circulation
□ chest pain
□ irregular heart beat
□ sleep with extra pillows
□ extremity swelling

Integumentary
□ rashes
□ lumps in breast

Endocrine
□ hormone therapy
□ excessive thirst
□ frequent urination

Past Medical History

_____ _____

_____ _____

_____ _____

_____ _____

Eye Diagnosis/Surgeries/Injuries

_____ _____

_____ _____

_____ _____

_____ _____

Eyes

□ blurry vision
□ flashing lights
□ floaters
□ double vision
□ watering
□ itching
□ burning
□ glare
□ red eye
□ eye pain
□ dry eye

TREASURE VALLEY | EYE CENTER

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT OF RECEIPT

The Treasure Valley Eye Center Notice of Privacy Practices provides information about how we may use and disclose protected health information about you.

I acknowledge that I have received the Notice of Privacy Practices and understand that I should read it carefully. I may obtain copies of the Notice by calling Treasure Valley Eye Center at 208-288-2020.

_____ _____

Signature of Patient or Patient's Representative Date

_____ _____

Print Name Relationship to Patient

_____

Interpreter (if applicable)

Please provide us with the name or names of people to whom we may disclose confidential information (other than spouse):

Name:_____ Relationship_____ Phone_____

Name:_____Relationship_____Phone_____

TREASURE VALLEY | EYE CENTER

Welcome to our office!
Thank you for choosing our office for your eye care services. Please take the time to complete our paperwork accurately and completely. This information is held in complete confidence as part of your permanent record and will not be released to anyone unless you authorize its release in writing.

Insurance Information
There are many types of health insurance carriers who provide many different types of medical and vision coverage. Because of this it is impossible for us to know specific coverage and benefits for all our patients. This office will do its best to obtain your benefit information while you are here; however, should questions arise regarding your benefits it is best for you to contact your insurance company directly. As a courtesy we will bill any medical insurance provided by the patient but we must have your most current insurance information prior to services being provided. **As a specialty clinic we will be billing your medical insurance.** If you have a separate vision plan we will bill that after we bill your medical insurance.

Payment
Due to insurance contracts, it is our policy to collect the insurance co-payment, co-insurance and non-covered service balances at the time of service. As a courtesy we will bill your insurance company for your appointment, however, this is NOT a guarantee of payment. After your insurance has processed your claim, you will be sent a statement for any outstanding patient balances. Accounts not paid after 90 days will be turned over to Collection Bureau, Inc. (CBI). You will be responsible for a monthly interest rate with CBI.

Important Information Regarding Refractions
A refraction is the process of determing whether you need glasses and/or contact lenses or if you have another problem with your eyes or vision. It is an essential part of the eye examination but most medical insurance plans, including Medicare and many other private insurance companies, do not cover routine eye examinations and they do not consider the refraction to part of the medical eye exam. By law we must bill the refraction charge seperately and it is the responsibility of the patient to pay for it. Our office fee for a refraction is $59.00 and we will collect this along with any co-payment, co-insurance and non-covered service balances at the time of service.

Cancellation Policy
We require a 72 hour notice for appointment cancellations. Appointments not cancelled within 72 hours will be subject to a $50 service charge. We do understand there will be emergent circumstances and will work with our patients in these situations.

I acknowledge that I have received a copy of Treasure Valley Eye Center's Notice of Privacy.
I authorize the release of any medical or other information necessary to process any claims arising from services and materials provided. I also request payment of government or private insurance benefits to the physician accepting assignment for the services and materials provided. I also understand that I assume financial responsibility for this account and all amounts due regardless of insurance coverage.

_____	_____
Signature	Date
_____	_____
Patient's Printed Name	Relationship to patient if guarantor