**Wade Family Eye Care Patient Registration Form**

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Name: \_\_\_\_\_\_\_\_\_\_\_\_\_

Address: ­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Eye Exam: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_(MM/YY) Mobile Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_ ZIP: \_\_\_\_\_\_\_\_\_\_ Secondary Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: ­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Date: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ Social Security Last 4: XXX-XX-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vision Insurance: ­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Care Doctor: ­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Carrier and Member ID # Name & Clinic Location

Medical Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Physical (MM/YY) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Carrier and Member ID #

Student Status: Not a student Full-Time Student Part-Time Student

Employment Status: Full-Time Part-Time Unemployed Retired Self-Employed

How did you find us? Google Facebook Insurance Directory Friend/Family

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Are you the primary insurance subscriber? Yes No (If not, please complete all items in this section)

Primary Subscriber’s Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PatientRelationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: Same as above \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_ ZIP: \_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Last 4: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: Same as Primary Subscriber \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Existing Conditions** – Please select all that apply

 Age Related Macular Degeneration Diabetes Glaucoma

 Cataract Diabetic Retinopathy High/Hyper Cholesterol

 Hypertension Borderline blood sugar Hypertension

 Borderline eye pressure None

**Ocular History**

 Blurred Vision Excessive watering Loss of central vision

 Burning Eye pain or soreness Loss of side vision

 Crusting on eyelashes Flashes/floating spots Mucous discharge

 Double Vision Glare/light sensitivity Sandy or gritty feeling

 Dryness Double Vision Issues with contacts

 Swelling Itching

Please indicate any of these that you have been told you have by a doctor

 Blindness Crossed eyes Lazy eye

 Retinal Detachment Choroidal melanoma Dry eye

 Keratoconus

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**Medical History**- The signs and symptoms of many diseases and disorders can be detected during your routine eye examination today and effect our findings. Please select any of the following conditions that you now have or have been treated for in the past.

 Developmental Disability Cancer Hearing loss Epilepsy/Seizures

 Dry mouth Multiple Sclerosis Stroke/CVA Migraine/Headaches

 Brain Tumor Depression Anxiety Bipolar Disorder

 Heart Disease Vascular disease Asthma Emphysema

 Sleep Apnea COPD Chronic Bronchitis Kidney/bladder disease

 Prostate cancer/disease Herpes Zoster/Shingles Herpes Zoster/ Cold Sores Hormonal dysfunction

 Arthritis Ankylosing Spondylitis Rosacea Psoriasis

 Type 1 Diabetes Type 2 Diabetes Hypothyroidism Hyperthyroidism

 Bleeding disorder Drug Allergies Environmental Allergies Rheumatoid Arthritis

 Sjogren’s Syndrome Lupus Other

Please list all medications you are currently taking:­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any allergies to medications? Yes No If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Yes No I currently wear eyeglasses Correct for Distance Reading Distance & reading

 Yes No I currently wear contact lenses Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Yes No I have had eye surgery to eliminate/reduce the need for eyeglasses

 Yes No I have had an eye operation Date: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

 Yes No I have had an eye injury Date: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ Injury: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Yes No I am pregnant and/or nursing

**Family & Social**

Do any blood relatives have any of the following medical conditions?

 Blindness Crossed Eyes High blood pressure Retinal detachment

 Diabetes Lazy eye Retinal disease Cataracts

 Glaucoma Thyroid disease Macular degeneration

**Marital Status**: **Social Status**:

 Single Married Widowed Living alone Living with family or friends

 Yes No I drive an automobile/motorcycle

 Yes No I consume alcohol

 Yes No I use tobacco products: Chewing tobacco Cigarettes Vape

**Office Policy** – Please read

**Payment Policy**: Payment for Doctor’s fees and Insurance co-payments are due at the time services are rendered. Balances on eyeglasses and lens materials must be paid in full at the time of dispensing. Our office shall provide insurance billing unless other arrangements have been made. We can only confirm insurance benefits. This is NOT the same as eligibility. In some cases, your medical services may not be covered by your insurance company for a given date of service. It is the patient’s responsibility for knowledge of insurance coverage and eligibility. If insurance coverage is denied for any reason payment will be the responsibility of the patient. You are responsible for keeping Wade Family Eye Care informed of any address or telephone changes. Should it become necessary to place your account with an outside collection agency due to lack of payment, you agree to pay all reasonable collection fees and related costs

**No cash refunds**: Due to the nature of eyewear, we regret there can be no cash refunds. Should a problem arise, such as an incorrect eyeglass or contact lens prescription done at our office we will re-fabricate or re-order the correct lenses to meet the required prescription as prescribed by the Doctor.

**We are not responsible for frame or lens breakage**: Although we take every precaution to prevent breakage, it does occasionally occur. We are sorry, but we can not be responsible for frames that are damaged while adjusting, fabricating new lenses, or during shipping. However, we will replace the frame or lenses that are purchased with Wade Family Eye Care while under warranty.

**Contact Lenses fees**: Most insurance carriers will not cover procedures related to contact lenses unless they are medically necessary. Most contact lenses are for cosmetic purposes and require additional fees. These fees include additional cost for the contact lens evaluations, follow-up care, dispensing, and contact lenses which are provided by our office.

**Insurance assignment and release**: I authorize payment of benefits directly to Wade Family Eye Care for services rendered. I also authorize the release of any medical information that may be required in determination of such benefits. I understand that some services may require approval or a referral from my primary care physician (PCP) for coverage and that I am responsible to obtain any and all referrals that my insurance company requires for services performed. If I do not obtain such approval, I am financially responsible for the services. I understand that my insurance carrier may not cover some services and products and therefore understand that I would be responsible for those charges. Deductibles and fees not paid by my insurance carrier will be my responsibility.

I acknowledge that I have read and understand Wade Family Eye Care’s office policy and received a copy of their “Notice of Privacy Practices HIPPA” policy.

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Patient Signature Date