PATIENT REGISTRATION
MID-PENINSULA OPHTHALMOLOGY MEDICAL GROUP, INC

*PLEASE **PRINT AND** COMPLETE **ALL** SECTIONS BELOW.*

ACCOUNT #__________________
CO-PAYMENT $________________

ALLIERGIES: __________________ DR. MR. MRS. MS. MISS

NAME: ______________________ (LAST NAME) ______________________ (FIRST NAME) __________ (INITIAL)

DATE OF BIRTH: ______ / ______ / ______ (MONTH / DAY / YEAR) SOCIAL SECURITY #______ - _____ - ______ SEX: M F

STREET ADDRESS: __________________________ (APT # ____) CITY: ______________ STATE: ______ ZIP: _________

HOME PHONE: (____) _______________ WORK PHONE: (____) ___________________ CELL (___) ________________

REFERRED BY: __________________________________ PRIMARY M.D.: __________________________________

EMPLOYER'S NAME: ____________________________________ OCCUPATION: __________________________________

ADDRESS: _________________________ CITY: _____________________ STATE: _____ ZIP CODE: _________________

SPOUSE'S NAME: _________________________ (LAST NAME) _________________________ (FIRST NAME) __________ (INITIAL)

DATE OF BIRTH: _____ / _____ / _____ (MONTH DAY YEAR) SOCIAL SECURITY: _____ - ____ - _____ WORK PHONE: (____) _____________

EMPLOYER'S NAME: ______________________________________ OCCUPATION: ____________________________

ADDRESS: ________________________________ CITY: ___________________ STATE: _____ ZIP CODE: _____________

COMPLETE THIS INFORMATION IF RESPONSIBLE PARTY IS OTHER THAN YOURSELF

RESPONSIBLE PARTY: SELF SPOUSE MOTHER FATHER OTHER _______________

NAME: _________________________ (LAST NAME) _________________________ (FIRST NAME) ____________ (INITIAL)

DATE OF BIRTH: ______ / ______ / ______ (MONTH / DAY / YEAR) SOCIAL SECURITY # ______ - _____ - ______

HOME PHONE: (____) ________________________ WORK PHONE: (____) ________________________

ADDRESS: __________________________ (APT # ____) CITY: _____________ STATE: ______ ZIP: ___________

PATIENT'S INSURANCE INFORMATION

PLEASE PRESENT INSURANCE CARDS TO RECEPTIONIST.

PRIMARY INSURANCE COMPANY'S NAME: ____

INSURANCE ADDRESS ___________________________________ CITY: _____________ STATE: ______ ZIP: ___________

NAME OF INSURED: ____ DATE OF BIRTH: _____ / _____ / _____ (MONTH / DAY / YEAR)

GROUP INSURANCE PROVIDED BY: ____________________________________ PHONE NUMBER: (____) ______________

RELATIONSHIP TO INSURED: SELF SPOUSE CHILD OTHER

INSURANCE ID NUMBER: ___________________________________ GROUP NUMBER: ______________________________

ASSIGNMENT OF BENEFITS/FINANCIAL AGREEMENT

I hereby give authorization for payment of insurance benefits to be made directly to Mid-Peninsula Ophthalmology, and any assisting physicians, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize Mid-Peninsula Ophthalmology Medical Group, Inc to verify information and to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

DATE: __________________________ YOUR SIGNATURE: ____

PATIENT HISTORY RECORD

PATIENT'S NAME____**SEX**__________**AGE**_______________________

SOC. SEC. NO.________________________________**PRIMARY CARE PHYSICIAN**___________________________

☐

Please answer the following questions about your medical history:

1. Have you ever been treated for any medical conditions (diabetes, high blood pressure, arthritis, etc?) .... Yes ☐ No ☐

   If YES, please explain: ____
2. Have you ever had any eye disease or surgery (glaucoma, cataract, wandering or "lazy" eye, retinal detachment)? .... Yes ☐ No ☐

   If YES, please explain: ____
3. Have you ever had any surgery? .... Yes ☐ No ☐

   If YES, please provide date and reason: ________________________________
4. Have you ever been hospitalized? .... Yes ☐ No ☐

   If YES, please provide date and reason: ________________________________
5. Do you take any medications? .... Yes ☐ No ☐

   If YES, please list: ____
6. Do you take any eye medications? .... Yes ☐ No ☐

   If YES, please list: ____
7. Do you have any DRUG or food allergies? .... Yes ☐ No ☐

   If YES, please list: ____
8. Do any medical or eye diseases run in your family (diabetes, high blood pressure, cancer, glaucoma, macular degeneration) Yes ☐ No ☐

   If YES, please explain: ____
9. Do you smoke? .... Yes ☐ No ☐

   If Yes, how much____
10. Do you drink alcohol? .... Yes ☐ No ☐

    If Yes, how much ____

Review of Systems

Do you currently have any of the following problems? (If YES, please explain in the space next to each question)

Chronic fever, unexpected weight loss/gain, fatigue____________________Yes ☐ No ☐

Ear/nose/throat problems (hearing loss, sinus problems, sore throat)____________________Yes ☐ No ☐

Heart problems (chest pain, irregular heart beat)____________________Yes ☐ No ☐

Respiratory problems (shortness of breath, wheezing, coughing)____________________Yes ☐ No ☐

Gastrointestinal problems (heartburn, abdominal pain, diarrhea, vomiting)____________________Yes ☐ No ☐

Urinary problems (pain or discomfort, blood in urine)____________________Yes ☐ No ☐

Skin problem (rashes, excessive dryness)____________________Yes ☐ No ☐

Musculoskeletal problems (muscle aches, joint pain, swollen joints)____________________Yes ☐ No ☐

Neurologic problems (numbness, weakness, headaches, paralysis)____________________Yes ☐ No ☐

Psychiatric problems (depression, anxiety)____________________Yes ☐ No ☐

If employed, how many hours do you work per week? _______________

Does your employment contribute to any stress in your life? .... Yes ☐ No ☐

____

Comments

____

M.D. Signature **Date**

MID-PENINSULA OPHTHALMOLOGY

OFFICE POLICIES

Welcome to our Office. Our goal is to provide you with the best medical care possible. To help answer questions that you may have we have outlined our policies below. We hope this information will be helpful to you. If you have additional questions or comments please feel free to discuss these with us at any time.

Our office hours are: 9:00 AM-Noon and 1:30-5:00 PM Monday through Friday.

PLEASE NOTE: Our doctors do NOT contract with any insurance plans. We will submit your claims to your insurance carrier but the charges are your responsibility.

PLEASE NOTIFY US 24 HOURS IN ADVANCE IF YOU NEED TO CANCEL OR CHANGE AN APPOINTMENT. IF YOU DO NOT NOTIFY US YOU WILL BE CHARGED FOR THE APPOINTMENT TIME. Emergency cases are seen immediately. Urgent cases are seen as soon as time permits. After hour emergency patients should go to the nearest hospital emergency room. There will be times when we have to reschedule your appointment due to changes in the surgery schedule or other events. We apologize for any inconvenience this may cause.

The initial appointment is approximately ½ to 1 hour long. Payment is required at the time of your visit. We accept cash, personal checks, VISA and Mastercard. We will need to take a copy of your insurance card.

We will bill your insurance for you as a courtesy. ***Refraction may not be covered by your insurance if they consider this to be routine. You are responsible for this charge.*** If there are problems with your insurance claim we will resubmit the claim at your request. **Your insurance policy is a contract between you and your carrier.** You are responsible for payment of your account regardless of the status of your insurance claim.

Medicare: Because we do not accept assignment, payment is required at the time of service. We submit your claims to Medicare. Medicare will pay you directly. If Medicare does not forward the claim to your second insurance directly they will provide you with the necessary information to file this yourself. Medicare does not cover refraction or other services they consider to be routine. You may call Medicare at 1-800-952-8627 with questions regarding Medicare policies, coverage, or you reimbursement.

Signature____Date____________________________