VIRGINIA PEDIATRIC EYE CENTER

Adult Registration Form

PATIENT INFORMATION: **REFERRED BY:** _____

Last Name: _____ First Name: _____ Middle:

_____

SSN: _____ DOB: _____ Sex: ☐ Male ☐

Female

Address:

_____

City: _____ State: _____ Zip: _____ PCP:

_____

Home Phone: (_____)_____Cell Phone: (_____)_____ Work Phone:

(_____)_____

Email Address:

_____

Marital Status: _____ Name of Spouse:

_____

Next of Kin: _____ Relation: _____ Phone:

(_____)_____

Occupation: _____ Employer:

_____

RESPONSIBLE PARTY (GUARANTOR) INFORMATION:

☐ Self ☐ Spouse ☐ Other: (Name, Relationship) _____

Address: _____ City: _____ State/Zip:

_____

SSN: _____ DOB: _____ Primary Phone:

(_____)_____

Email Address:

_____

Guarantor's Employer: _____ Work Phone:

(_____)_____

INSURANCE INFORMATION: (PLEASE PRESENT YOUR INSURANCE CARDS AND/OR VALID REFERRAL)

I understand that I will be responsible for all charges not paid or denied because I did not provide complete and accurate information herein:

Primary Insurance: _____***Policy ID #:***_____

_

Policy Holder's Name: _____ Birth Date:

_____

Secondary Insurance: _____ ***Policy ID #:____***

_____

Policy Holder's Name:_____ Birth Date:

_____

PRIMARY CARE PHYSICIAN:_____ Phone: (_____)_____

Address

_____

AUTHORIZATION FOR MEDICAL CARE, NOTICE OF PRIVACY PRACTICES AND BILLING RESPONSIBILITIES:

I hereby authorize treatment to the patient by the physicians and/or staff of Virginia Pediatric Eye Center (VPEC). I also authorize release of medical information necessary to process the insurance. I understand that failure to cancel future appointments with less than 24 hours notice may incur a fee of up to $50. I agree to reimburse VPEC the fees of any collection agency, which may be based on a percentage at a maximum of 30% of the debt, and all costs, and expenses, including reasonable attorney's fees, VPEC incurs in such collection efforts. I also that I have been given the opportunity to read the Notice of Privacy Practices for VPEC; this notice describes how medical information about me may be used and disclosed and how I can get access to this information. (A copy of the privacy notice is available upon request.)

Signature: _____Relationship to Patient:_____ Date: _____

For Office Use Only:
Reviewed Back and Front by: _____, Date: _____; PM Updated by: _____, Date: _____

PATIENT'S MEDICAL HISTORY **Last Eye Exam (Date)_____ (Doctor)**

_____

What is the problem that brings you to Virginia Pediatric Eye Center?

_____

_____

Has there been any treatment for this problem? If so, please describe:

_____

_____

__

Has the patient ever had any eye diseases (e.g. cataracts, glaucoma, wandering or "lazy" eye, retinal detachment)? If so, please describe:

_____

Are there other physicians involved in the patient's eye care? If so, please list name, address, and phone number of the doctor(s):

_____

_____

__

Is there any family history of medical problems or eye disease (e.g. high blood pressure, cancer, cataracts, strabismus/lazy eye, diabetes/sickle cell trait, glaucoma, etc)? If yes, please explain:

_____

_____

__

Has the patient ever been diagnosed and/or treated for any medical condition (e.g. diabetes, juvenile rheumatoid arthritis, congenital defects, genetic disorders, ADHD, etc)? If so, please explain,

_____

_____
__

Has the patient ever had any surgery? If so, please provide date and procedure:

_____
_____
__

Has the patient ever been hospitalized? If so, please provide date and reason:

_____
_____
__

Please list the patient's present medications, including vitamins and over-the-counter drugs:

_____
_____
__

Please list the patient's allergies:

_____

REVIEW OF SYSTEMS

Does the patient have any of the following problems:	YES	NO	If YES, please explain:
Chronic fever, unexpected weight loss/gain, fatigue	☐	☐	_____
Ear/nose/throat problems (hearing loss, sinus problems, sore throat) ☐	☐		_____
Heart problems (chest pain, irregular heart beat)	☐	☐	_____
Respiratory problems (shortness of breath, wheezing, coughing)	☐	☐	_____
Gastrointestinal problems (heartburn, abdominal pain, diarrhea, vomiting)	☐	☐	_____
Urinary problems (pain or discomfort, blood in urine)	☐	☐	_____
Skin problems (rashes, excessive dryness) ☐	☐		_____
Musculoskeletal problems (muscle aches, joint pain, swollen joints)	☐	☐	_____
Neurologic problems (numbness, weakness, headaches, paralysis)	☐	☐	_____
Psychiatric problems (depression, anxiety)	☐	☐	_____

Eyes: (If YES, please CHECK)

Loss of vision	☐	Foreign body sensation	☐
Blurred vision	☐	Excess tearing/watering	☐
Distorted vision (halos)	☐	Occasional tearing	☐
Loss of side vision	☐	Glare/Light sensitivity	☐
Double vision	☐	Eye pain or soreness	☐
Dryness	☐	Chronic infection of eye/lid	☐
Mucous discharge	☐	Styes, Chalazion	☐
Sandy or gritty feeling	☐	Fluctuating visual acuity	☐
Itching	☐	Tired eyes	☐
Burning	☐		