

METROLINA EYE ASSOCIATES, PLLC Registration Form

Today's Date:				PCP:			
PATIENT INFORMATION							
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		(Former name):		Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Social Security no.:		Home phone no.: ()		
P.O. Box:		City:		State:		ZIP Code:	
Occupation:		Employer:			Employer phone no.: ()		
Chose clinic because/Referred to clinic by (please check one box):				<input type="checkbox"/> Dr.		<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Hospital
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other			
Other family members seen here:							
INSURANCE INFORMATION-PLEASE GIVE INSURANCE CARD TO RECEPTIONIST							
Person responsible for bill:		Birth date: / /	Address (if different):			Home phone no.: ()	
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Occupation:	Employer:	Employer address:				Employer phone no.: ()	
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Please indicate primary insurance		<input type="checkbox"/> BC & BS	<input type="checkbox"/> Medicare	<input type="checkbox"/> Aetna	<input type="checkbox"/> Cigna	<input type="checkbox"/> UHC	
<input type="checkbox"/> MedCost	<input type="checkbox"/> Medicaid-NC (only)	<input type="checkbox"/> Eye Med	<input type="checkbox"/> VSP		<input type="checkbox"/> Other		
Subscriber's name:		Subscriber's S.S. no.:	Birth date: / /	Group no.:		Policy no.:	Co-payment: \$
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		
Name of secondary insurance (if applicable):		Subscriber's name:		Group no.:		Policy no.:	
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		
IN CASE OF EMERGENCY							
Name of local friend or relative (not living at same address):			Relationship to patient:		Home phone no.: ()	Work phone no.: ()	
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Metrolina Eye Associates or my insurance company to release any information required to process my medical claims.							
Patient/Guardian Signature:				Date			

MEDICAL HISTORY

NAME _____ MARITAL STATUS _____ DATE OF BIRTH _____

MEDICAL HISTORY: Check all that apply:

Diabetes _____ Hypertension _____
Asthma _____ Heart Disease _____
Lung Disease _____ Heart Attack _____
Kidney Disease _____ Migraine _____
Dialysis _____ Cancer _____
Arthritis _____ Stroke _____
LIST ANY OTHER HEALTH PROBLEMS: _____

LIST PAST SURGERIES AND DATES: _____

CURRENT MEDICATIONS: (we can copy if you have them listed): _____

DRUG ALLERGIES: _____

REASON FOR THIS VISIT: _____

REFERRED BY: _____

HAVE YOU HAD A PROBLEM WITH YOUR EYES IN THE PAST? _____ Please List _____

DO YOU WEAR GLASSES? _____ CONTACTS? _____

FAMILY HEALTH HISTORY:

List any serious health problems or the cause of death of these relatives:

FATHER _____

MOTHER _____

BROTHERS/SISTERS _____

CHILDREN _____

DO ANY EYE DISEASES RUN IN YOUR FAMILY? _____

Circle all that apply: Glaucoma, cataracts, crossed eyes, diabetes, macular degeneration, retinal disease, other _____

LIST ANY OTHER DISEASES THAT RUN IN YOUR FAMILY: _____

SOCIAL HISTORY:

check all that apply now or in the past:

Tobacco Use _____ Packs per day _____

Alcohol Use: never _____ occasionally _____
weekly _____, daily _____

Recreational Drug Use: _____ HIV _____

LAST GRADE COMPLETED IN SCHOOL OR THE GRADE YOU ARE IN NOW _____

REVIEW OF SYSTEMS: Do you presently have or have you recently had any of the following symptoms? Circle all that apply:

EAR, NOSE, THROAT OR MOUTH SYMPTOMS:

deafness, ringing in ears, sore throat
sinus problems, nasal discharge, other

CARDIOVASCULAR SYMPTOMS:

chest pains, palpitations,
irregular heart beat, other

RESPIRATORY SYMPTOMS:

shortness of breath, wheezing, cough, other

GASTROINTESTINAL SYMPTOMS:

loss of appetite, abdominal pain,
nausea, other

GENITOURINARY SYMPTOMS:

frequent or painful urination
sexually transmitted disease, other

CONSTITUTIONAL SYMPTOMS:

headache, fever, weight loss, other

MUSCULOSKELETAL SYMPTOMS:

arthritis, weakness, gout, other

SKIN/BREAST SYMPTOMS:

lesions, masses, changes in hair or nails,
rash, itching, other.

NEUROLOGICAL SYMPTOMS:

paralysis, numbness, convulsions,
loss of smell, taste or speech, other

HEMATOLOGIC/LYMPHATIC SYMPTOMS:

anemia, swollen lymph glands,
abnormal bleeding, other

ALLERGIC/IMMUNOLOGIC SYMPTOMS:

dermatitis, asthma, seasonal allergies,
other

ENDOCRINE SYMPTOMS:

thyroid disease, excessive thirst or hunger,
other

PHSYCHIATRIC SYMPTOMS:

anxiety, other

PATIENT SIGNATURE: _____

DATE: _____

REVIEWED BY: _____ M.D. / CMA / LPN / RN / OTHER / DATE _____

METROLINA EYE
A S S O C I A T E S
A Clear Vision of Excellence

MEDICAL INSURANCE vs. ROUTINE VISION PLANS

Routine vision plans such as VSP, Community Eye Care, Superior Vision, Opticare and others provide coverage for a basic screening eye exam to ensure the health of your eyes and for checking for the need for glasses and contacts. Benefits vary according to the specific plan, but routine vision plans DO NOT cover a medical diagnosis.

If during the course of your examination it is discovered that you have a medical issue such as eye allergies, redness, burning, itching, dryness, infection; glaucoma; cataracts; diabetes; headaches or any other eye related medical issue or complaint; we will not be able to treat you under your routine policy. We treat these medical problems under your medical insurance, which generally has a higher co-pay or deductible.

We know your time is valuable, and we would like to take care of all of your eye care during one visit. However, sometimes this is not possible. Some medical issues interfere with our ability to properly fit you for glasses or contacts until the issue is resolved. In this case we will gladly schedule you for a routine exam as soon as possible. If you have a medical condition that does allow for a new eyeglass prescription, we will gladly do that while you are here.

Note: Your specific vision plan may not cover an eyeglass fit (refraction) when performed during a medical visit. In this case, you will be responsible for the cost of the refraction in addition to your medical co-pays. Any amount that you are responsible for is due at the time of service.

We strive to deliver the best care for your particular issues whether they are routine or medical.

By signing this statement, you agree that you have read and understand the difference in coverage for your routine vision plan and your medical insurance plan.

Patient Name (please print)

Parent/Guardian Name (please print)

Date of Birth

Parent/Guardian Signature

Patient Signature

Date