Southern Eye Associates

PATIENT REGISTRATION FORM

Today's Date: _____

PATIENT INFORMATION:
Last Name: First: Middle:
Gender: ☐ Male ☐ Female
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow/Widower ☐ Other
Spouse's Name (if applicable):
Patient's Date of Birth:
Preferred Language:
Address: City: State: Zip:
Social Security Number:
Email address:
Preferred method of contact: ☐ Phone ☐ Email ☐ Text
Home Phone: Cell Phone:
Ethnicity: ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American
☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ Caucasian/White
Work: ☐ Full-time ☐ Part-time ☐ Doesn't work
School: ☐ Elementary Student ☐ High School Student ☐ College Student
Living Situation: ☐ Lives with family ☐ Lives alone ☐ Lives in facility
Occupation: Employer:
Employer Address: Employer Phone:
Emergency Contact: Emergency Phone:
Preferred Pharmacy: Pharmacy Location:
PERSON RESPONSIBLE FOR ACCOUNT (if other than self):
Name: Relationship: Date of Birth:
SSN: Employer:
INSURANCE INFORMATION:
Primary Medical Insurance:
Policy Number: Group Number:
Policy Holder: Relationship:
DOB: SSN: Employer:
Secondary Medical Insurance:
Policy Number: Group Number:
Do you have one of these vision plans? ☐ VSP ☐ Spectera ☐ Eyemed ☐ Physicians Eyecare
FAMILY DOCTOR:
REFERRING DOCTOR (if applicable):
By signing this document, I confirm my information to be correct.
Signature: Date:

Southern Eye Associates

FINANCIAL POLICY

Thank you for choosing Southern Eye Associates of SC, PA as your health care provider. Please understand that payment for provided services is due at the time services are rendered. We accept cash, checks and all major credit cards. Any additional testing, **including refractions**, **are an additional charge**.

If You Have Insurance

When we are a Participating Provider, all applicable Co-payments, Deductibles, Lens Fitting and Refraction charges, which are not covered by your insurance company, are **due at the time the service is provided**. ***Refraction*** tests are $40.00 and are necessary to determine if your eye prescription has changed, or if glasses will be necessary to correct your vision. **Medicare** and many supplemental insurances do NOT cover this test. All non-covered services, such as refraction testing, will be the responsibility of the patient and are due at the time of the service.

We will bill your insurance company: however, the remaining balance of the bill is your responsibility, whether or not your insurance company pays. Your insurance policy is a contract between the insurance company and yourself. Please note that some, perhaps all, of the services provided may be non-covered under the Medicare program. **When we are NOT a Participating Provider**, the patient is fully responsible for all charges.

Collection Fees

All returned checks, regardless of reason, will be assessed a $25.00 fee and any additional collection expenses incurred to recover the original amount due for the medical services rendered.

By signing below, I agree to pay all amounts owed when due. I understand that it is my responsibility to provide my correct/updated insurance information and that this office will bill my insurance as a courtesy to me. However, regardless of insurance coverage, I agree that it is and shall remain my responsibility to pay all amounts owing as set forth herein. In the event any amount(s) is/are referred to a third-party debt collection agency, I agree that in addition to any other amount (s) allowed for by law, (such as interest, court costs, reasonable attorney's fees, etc.)

The terms of this paragraph shall apply to all amount (s) incurred by me or by any individual for whom I have legal responsibility whether such amount (s) are incurred today or after today. I understand that it is my responsibility to provide my correct/updated insurance information and that this office will bill my insurance as a courtesy to me.

I hereby consent to being contacted by telephone at any telephone number (including but not limited to wireless/cellular phone numbers) provided by me or anyone associated with me or acting on my behalf to Southern Eye Associates of SC, PA or anyone acting on its behalf. I understand and agree that such calls may be initiated by Southern Eye Associates of SC, PA or any of its affiliates, agents, contractors or assigns, including but not limited to billing companies and/or third party collection agency (ies), and the methods of contact may include using pre-recorded/artificial voice messages and/or the use of an automated dialing device and/or the use of text messages- some or all of which may result in data charges. I also consent to receiving e-mails at any e-mail address provided by me or anyone associated with me acting on my behalf.

Acknowledgement of Privacy Practice

We are required to notify you of our privacy practices, and have you sign that you have reviewed this information. Southern Eye Associates of SC, PA maintain a record of each patient visit, describing your history, symptoms, exam findings, diagnosis, and suggested treatment. Medical records are needed to provide you with proper care, coordinate with other physicians involved with your care, and for communication with your insurance company. We do not share your personal medical information with any unauthorized entity without your permission. More details of our Notice of Privacy Practices may be found in our written publication.

I have been given a copy of the Southern Eye Associates of SC, PA Notice of Privacy Practices, which describes how my health information is used and shared. I understand that Southern Eye Associates of SC, PA has the right to change this notice at any time.

I would like to authorize my medical information to be disclosed/released with the following person (s):

Name:	Relationship:	Phone:
Name:	Relationship:	Phone:
Name:	Relationship:	Phone:

This authorization permits Southern Eye Associates to release your protected health information to the above person or persons without any further authorization from you. YOU may revoke this authorization in writing and send to Southern Eye Associates, 113 Doctors Drive, Greenville, SC 29605.

My signature below acknowledges that I have read and understand the Notice of Privacy Practices.

Signature _____ Date: _____

Signature of Patient or Responsible Party

Southern Eye Associates

MEDICAL QUESTIONNAIRE

Patient Name: _____Account#_____Date:_____

Reason for Exam today: _ _____

Worker's Compensation Visit ☐ YES ☐ NO Injury or Trauma ☐ YES ☐ N0☐

Please check if you have any of the following:

Do you have:	How Long:	Do you have:	How long:	Do you have	How long:
Blurred Vision		Dryness		High Blood Pressure	
Redness		Soreness/Irritation		Diabetes	
Burning/Pain		Burning		Asthma	
Itching		Eye Fatigue		Emphysema	
Excess Tearing/Watering		Macular Degeneration		Heart Disease	
Tired Eyes		Cataracts		Cancer	
Constant Lens Discomfort		Retinal Detachment		Other Problems	
Feeling of sand/grit		Lazy Eye		Glaucoma	
Light Sensitivity		Other Eye Problems			

Does anyone in your IMMEDIATE family have any of the above problems or diseases _____

If so, who and what is their relationship to you?

Do you currently wear eyeglasses? ☐YES ☐ NO Do you currently wear contact lenses ☐YES ☐ NO

What is the current brand of contact lenses you are wearing? _____

Do you use alcohol ☐ Yes ☐ No If yes, how much? _____

Do you use tobacco ☐ Yes ☐ No If yes, how much? _____

Eye Surgery:

Cataract Surgery	
Glaucoma	
Refractive (LASIK)	
Other (list type)	

SYSTEMIC REVIEW OF SYSTEMS

Please check any that apply to you:

☐Weight loss or Weight Gain Problems
☐Numbness / Headaches
☐Painful joints
☐Thyroid problems
☐Chest pain
☐Frequent Urination
☐Loss of smell
☐Easily bleeding
☐Skin rashes
☐Mental Health
☐Intestinal problems
☐Shortness of breath
☐Painful joints
☐Diabetes
☐Double Vision
☐Allergies

LIST ALLERGIES TO ANY MEDICATIONS:

_____

_____

Please list all Medications:

Name of Medication	Dosage	Times Per Day		Name of Medication	Dosage	Times Per Day

***NOTE:** Please bring your current medications in their current prescription bottle to your initial appointment