Grove Eye Center Patient Registration

Patient Information

Patient Name: _____

Gender: _____ Date of Birth: _____ Marital Status: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone#: _____ Cell Phone #: _____ Work Phone: _____

Social Security Number: _____ Email: _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Emergency Phone #: _____

Insurance

Name Of Insurance Company: _____ Insurance Group Number: _____

Full Name of Policy Holder: _____ Policy Holder's SSN: _____

Policy Holder Employer: _____ Policy Holder Date of Birth: _____

Patient Relationship to Policy Holder: _____

I certify that I, and /or my dependent(s) have insurance coverage with _____ and assign directly to Dr. Lay/Yandell all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature: _____ **Date:** _____

Medicare/Medigap Authorization

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to Grove Eye Center for any services furnished to me by that provider. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

Signature: _____ **Date:** _____

Medical Information

Name If Primary Care Physician: _____

List all health problems: _____

_____

List all medications you are currently taking: _____

_____

List all medication allergies: _____

Family Medical History (list medical problems): _____

Are you diabetic? _____ Are you pregnant? _____ Do you smoke? _____ Do you drink alcohol? _____

Eye Health History

Do you wear glasses? _____ Do you wear contacts? If so which brand? _____

List all eye surgeries: _____

List all eye drops you are currently taking: _____

Does anyone in your family have glaucoma, macular degeneration or other eye disease? If so list which disease and relative. _____