

Bridgeport Eye Center



Patient Registration Forms

Patient Information

Patient's Name	
Date of Birth	
Social Security Number	
Address	
City, State, Zip code	
Driver's License Number	
Phone Number	
Email Address	
Occupation & Employer	
Work Address	
City, State, Zip-code	
Work Phone Number	

Gender	
Race	
Ethnicity	
Preferred Language	
Employment Status	
Marital Status	

Insurance Subscriber Information

Subscriber Name & Relationship	
Date of Birth	
Social Security Number	
Insurance Company Name	
Subscriber ID & Group Number	

Emergency Contact Information

Emergency Contact Name	
Relationship to Patient	
Phone Number	

If the Patient is a Minor

Parent/Guardian's Name	
Date of Birth	
Social Security Number	
Driver's License Number	
Phone Number	

Patient/Guardian Signature _____ Date _____

Bridgeport Eye Center



Financial Agreement

All patients who provide their insurance information prior to being seen or present it in office at the time of their appointment will have benefits verified. Your carrier will be contacted by telephone by our insurance clerk who will verify your coverage effective date, limitations and benefits for both examination and materials. This information is provided to us by an employee of your insurance company and we rely on them to provide accurate and up to date information. Our claims are filed in a timely manner and processed electronically. Within the past twelve months we have experienced a significant increase in claims processing that does not match the verbal benefits which were given at the time of certification. Errors in coverage provided to us by your insurance company prior to being seen do not alleviate financial responsibility for services obtained. If your claim processes differently than what we were informed of regarding your benefits, you will receive an additional bill from this office. The patient is ultimately responsible for services obtained at **Bridgeport Eye Center**.

Insurance Consent

Our office files some types of insurance. If you will be attempting to use insurance for your visit today, you must present your insurance card to the receptionist PRIOR to being seen by the doctor. Some types of insurance we do not file directly by we will help you file so that you may be reimbursed by your carrier for expenses in our office. It is the responsibility of the patient to be certain that you are covered for services and that you inform the staff of your benefits when completing this form. The staff will verify your benefits with your carrier. If your appointment is delayed due to benefit verification, the appointment may be rescheduled. All co-pays are due on the date of service. No minor may be examined without a parent in the examination room. We do not verify benefits after an appointment has been complete. No exceptions. In other words, if you do not have proof of coverage and benefits verified you may NOT present this information later and have a claim filed on your behalf. It is the patient’s responsibility to know who their insurance carrier is.

Consent for the Use and Disclosure of Protected Health Information (HIPAA)

The Privacy practice of Bridgeport Eye Center are contained in the Notice of Privacy practices. A viewable copy of this document is available at the front desk. If you wish to obtain a copy of the Privacy Practices, please inform a staff member and a copy will be provided to you at no cost. Your signature below indicates you were able to review the Bridgeport Eye Center’s Notice of Privacy Practices, which explains how your medical health information will be used and disclosed. By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The patient has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosure will then cease.

Bridgeport Eye Center may call my cell/email/text and leave a message about any terms that assist in the practice of carrying out treatment, payment, or health care operations.	YES / NO
Bridgeport Eye Center may mail to my home or other mailing address any items that may assist the practice of carrying out treatment, payment, or health care operations.	YES / NO

By signing below, I have read and understand the policy above,

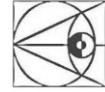
Patient Name (Print)

Date of Birth

Patient/Guardian Signature

Todays Date

Bridgeport Eye Center



Reason for your visit today: _____

Your Eye Health History

Any injuries to your eyes _____

Any eye surgeries _____

Any eye medications (drops, ointment, etc.) _____

Do you have any trouble seeing at night Yes No

Last eye exam _____ Last eye Doctor _____

Primary Vision Correction: (please check one)

Single Vision Glasses Bifocal Glasses Progressive Lens Glasses Contacts

Contact Lens Wearer: Hard/Rigid Contact Soft Contacts

If Soft Contacts: How often do you discard them _____ What solutions do you use _____ How many hours do you wear them each day _____

Your Family Eye Health History

Does anyone in your family have one of these eye problems? (check all that apply)

Glaucoma Macular Degeneration Retinal Detachment Cataracts before age 65

Crossed/Lazy Eye Other _____

Your Medical History

Diabetes YES NO

HTN/High Blood Pressure YES NO

High Cholesterol YES NO

Thyroid Disease YES NO

Cardiovascular/Heart YES NO

Cancer YES NO

Other _____

Your Family's Medical History

Diabetes YES NO

HTN/High Blood Pressure YES NO

High Cholesterol YES NO

Thyroid Disease YES NO

Cardiovascular/Heart YES NO

Cancer YES NO

Other _____

Medications/Allergies/Other History

Current Medication's (if you have a list, present it to front desk) _____

Medication Allergies _____ Other Medications _____

Vitamins _____ Herbals/Other _____

Primary Doctor Name _____ Phone Number _____

Name of any Specialist you see _____

Last visit with your Primary Care Doctor _____ Reason for visit _____

Major injuries, surgeries, or hospitalizations _____

Are you pregnant or nursing YES NO

Did You receive a FLU SHOT within the last 12 months YES NO

Are you current on Tetanus vaccination YES NO

Social History

Occupation _____ Hobbies that affect or use vision _____

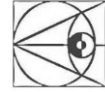
Smoking Status: YES NO Type: Cigarette Cigar Other How long: _____

Alcohol Status: YES NO Type: Beer Wine Liquor How long: _____

Illegal Drugs: YES NO Type: _____ How long: _____

Exposure to Hepatitis, AIDS, HIV, HPV or any STD: YES NO

Bridgeport Eye Center



Review of Systems:
(check all that apply)

- General:** Good Health Overall Fatigue Fever
- Ear, Nose & Throat:** Cough Dry Mouth Congestion Allergies
- Cardiovascular:** Heart Disease High Blood Pressure Vascular Disease
- Respiratory:** Asthma Bronchitis Emphysema COPD
- Genito-Urinary:** Kidney Problems Bladder Problems Prostate Problems
- Muscles, bones, joints:** Arthritis Degeneration
- Gastrointestinal:** Crohn's Disease IBS Stomach Upset Acid Reflux
- Skin:** Eczema Itching Rosacea Acne
- Neurological:** Headaches Migraines MS Numbness Seizures
- Psychiatric:** ADHD Anxiety Depression
- Endocrine:** Diabetes/Child Diabetes/Adult Thyroid
- Blood/Lymph:** High Cholesterol Anemia Bleeding Disorder
- Allergic/Immunologic:** Seasonal
- Other/Notes:**