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		Your Family's Medical History	
Diabetes	☐YES ☐NO	Diabetes	☐YES ☐NO
HTN/High Blood Pressure	☐YES ☐NO	HTN/High Blood Pressure	☐YES ☐NO
High Cholesterol	☐YES ☐NO	High Cholesterol	☐YES ☐NO
Thyroid Disease	☐YES ☐NO	Thyroid Disease	☐YES ☐NO
Cardiovascular/Heart	☐YES ☐NO	Cardiovascular/Heart	☐YES ☐NO
Cancer	☐YES ☐NO	Cancer	☐YES ☐NO
Other_____		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:				