Lakeway Eye Physicians and Surgeons, P.A.
Corina A. Stancey, MD
1310 RR 620 South, Suite B-201
Austin, TX 78734
512-402-9919

PATIENT REGISTRATION FORM

Name_________________________________Soc .Sec #_____________________

Address____
Street City State Zip

Phone ( )________Date of Birth__/__/__ Age__Sex M F Marital Status S M D W

Employer_________________________________Occupation__________________
Name City State Zip Phone

Primary Care Physician____________________Optometrist_____________________

Referral Source: ___Primary Care Physician ___Optometrist ___Family member/Friend
___Newspaper Ad ___Direct Mail ___Magazine ___Phone book ___Internet
___Insurance Co.

Primary Insurance Carrier____
Subscriber's Name_____________________Subscriber's Date of Birth______
Subscriber's Soc Sec #_______________Relationship to Patient___________
Secondary Insurance Carrier____
Subscriber's Name___________________ Subscriber's Date of Birth_______
Subscriber's Soc Sec # _______________Relationship to Patient___________

Guarantor (The Person Responsible for Payment – If Not the Patient)______________
Address____
Guarantor Date of Birth_______Guarantor's Soc Sec #__________________

ALL PAYMENTS AND CO-PAYMENTS ARE EXPECTED AT TIME OF SERVICE

INSURANCE BENEFITS:

Lakeway Eye Physicians and Surgeons will file claims with your insurance carrier as a courtesy to you. Ultimately, the contract exists between you and your insurance carrier. We will attempt to verify benefits and coverage prior to your visit, however, there is no guarantee that payment will be made for services rendered. If you need a consent or referral from your Primary Care Physician, it is your responsibility to obtain one.

Contact Lens fittings and lenses are not included in the cost of a complete eye exam. Most insurance companies will not cover the cost of contact fittings. You may be responsible for this service.

I understand that I am fully responsible for any and all charges incurred. I further understand that all payments and co-payments are expected at time of service. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize and direct my insurance carrier(s), Medicare, private insurance, and any other health/medical plan, to issue payment check(s) to Lakeway Eye Physicians and Surgeons for medical services rendered to myself or my minor children regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance. If I need a consent or referral from my Primary Care Physician, and have not obtained one, I understand I am financially responsible for charges incurred. I understand that if my account is delinquent and is turned over to a collection agency, I will be responsible for all collection costs. If you shoose to pay by check and your check is dishonored, you agree to pay a processing fee of $30, or any higher amount allowed by law, and we may electronically debit or draft your account for this fee. Also, if your check is returned for insufficient or uncollected funds your check may be electronically re-presented for payment.

I hereby authorize Lakeway Eye Physicians and Surgeons to: 1) release any information necessary to insurance carriers regarding my treatments 2) process insurance claims generated in the course of examination and 3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

SIGNATURE:______________________________DATE:______________

PATIENT MEDICAL HISTORY:

Name_________________________________
Date of Birth____________Date___________

Do you have or have had any of the following conditions or problems? (please circle positives)
Constitutional - weight loss/gain, fatigue, etc.
Ear/Nose/Throat - hearing loss, sinus problems
Cardiovascular - high blood pressure, heart problems, heart attacks, pacemaker
Endocrine – diabetes, thyroid problems, Grave's disease
Hematologic/Lymphatic – Aids, HIV+, hepatitis, high cholesterol
Respiratory – asthma, emphysema, bronchitis, tuberculosis
Gastrointestinal – heartburn, ulcer
Integumentary – rashes, rosacea, breast problems, healing problems/keloid formation
Musculoskeletal – arthritis, lupus, gout, osteoporosis
Neurological – headaches, stroke, multiple sclerosis, paralysis
Psychiatric – depression, anxiety, clausterphobia
Allergic/Immunologic – seasonal allergies, hay fever

Have you ever had any surgery (not including eyes)? Y N ______________________________
Have you ever had any head injuries? Y N ____

Are you ALLERGIC to any medications? Y N ____________________________________
Are you currently taking ANY medications? Y N _________________________________

Do you smoke? _____yes ____no If yes, how much per day? ______________________________
Do you drink alcohol? _____none ____rarely ____socially ____daily

Do you have any FAMILY HISTORY of the following? If so, please list relationship.
Blindness Y N ____
Diabetes Y N ____
Glaucoma Y N ____
Macular Degeneration Y N ____
Retinal Detachment Y N ____
High Blood Pressure Y N ____
Other (explain) Y N ____

Eye History

Do you wear glasses? Y N Do you wear contact lenses? Y N ___soft ___hard
Do you have any history of eye disease? Y N __________ __________________________
Have you ever had an eye injury or eye surgery? Y N __________________________________
Are you currently taking any eye medications? Y N ______________________________

Physician Signature____Date__________________