

Lakeway Eye Physicians and Surgeons, P.A.

Corina A. Stancey, MD

1007 RR 620 South, Suite 100

Lakeway, TX 78734

512-402-9919

PATIENT REGISTRATION FORM

Name _____ Soc. Sec # _____

E-mail Address: _____

Do you prefer to be contacted for appointment confirmations by e-mail or phone ?

Address _____

Street

City

State

Zip

Phone () _____ Date of Birth ___/___/___ Age ___

Sex: M F Marital Status: S M D W

Employer _____

Name

City

State

Zip

Work Phone _____ Occupation _____

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 choose 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.

Cancellation Policy: Please understand that missed appointments or cancellations with less than 24 hours notice will be subject to a \$50 cancellation fee.

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 ☞

Date: _____

Name: _____

Date of Birth: _____

Are you ALLERGIC to any medications (Describe)? Y N _____

Are you currently taking ANY medications (Describe)? Y N _____

Are you currently taking any EYE medications (Describe)? Y N _____

Do you wear glasses? Y N Do you wear contact lenses? Y N soft hard

Do you have any history of eye disease (Describe)? Y N _____

Have you ever had an eye injury or eye surgery? (Describe & include year) Y N _____

Do you have or have you had any of the following conditions or problems? (PLEASE CIRCLE)

- 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, Graves disease
- Hematologic/Lymphatic: HIV+, AIDS, 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, claustrophobia
- Allergic/Immunologic: seasonal allergies, hay fever

Have you ever had any head injuries? (Describe & include year) Y N _____

Have you ever had surgery not including eyes? (Describe & include year) Y N _____

Do you have any FAMILY HISTORY of the following? If so, please list relationship (mother, grandfather, etc.)

Y N Blindness: _____ Y N Cancer: _____
Y N Cataracts: _____ Y N Diabetes: _____
Y N Diabetic Retinopathy _____ Y N Heart Disease: _____
Y N Glaucoma: _____ Y N High Blood Pressure: _____
Y N Macular Degeneration: _____ Y N Stroke: _____
Y N Retinal Detachment: _____ Y N Other (explain): _____

Do you smoke? Y N Amount per day for how many years? _____

Do you drink alcohol? none rarely socially daily: drinks per day: _____

Physician's Signature: _____ Date: _____