PATIENT REGISTRATION FORM

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms ☐ Dr. ☐ Pastor ☐ Captain

________________________________ ___ __________________________
First Name MI Last Name

Street Address: ____

City ___________________________ State _______________ Zip _________________

Social Security # ____-____-_____ Date of Birth: ____________________ ☐ Male ☐ Female

Home # __________________ Work # ____________________ Mobile # ___________________

Email: ____________________________________ Preferred Contact ☐Home ☐ Work ☐Mobile

I authorize Georgia Eye Partners to communicate my protected health information to me with a detailed message via the following methods: ☐ Voicemail (home or mobile #) ☐ E-mail
☐ I do not authorize Georgia Eye Partners to leave detailed messages on voicemial or email

I agree to receive text messages to the above mentioned mobile number reminding me about my upcoming appointments. I understand that SMS reminders are optional and that message & data rates may apply. ☐ Yes ☐ No

---

Emergency Contact Information

__________________________ _____________________ Relationship: _____________________
First Name Last Name

Home # __________________ Work # ____________________ Mobile # ___________________

Occupation ______________________________

Race _________________ Ethnicity ___________________ Language ___________________

Referring Physician: ____

Eye Doctor: ____

Primary Care Physician: ____

Designated HIPAA Release & Communication

At my request, I authorize Georgia Eye Partners to disclose my protected health information to:

Name: ______________________________ Relationship _________________ Phone _______________

Name: ______________________________ Relationship _________________ Phone _______________

Medical Insurance Information

Insured Party Name: ____________________ ___________________________ ☐ Same as Patient
First Last

Street Address: ____

City ___________________________ State _______________ Zip _________________

Date of Birth: ________________ Social Security #: ____-____-_____ Home #: _______________

Patient Relationship To Insured: ☐ Self ☐ Child ☐ Spouse ☐ Other Gender: ☐ Male ☐ Female

Insurance Company Name: ___________________________________

Insurance Plan Name: _____________________________ Type: ______________________

Insurance ID Number: ____________________________ Policy # ____________________

Notice of Privacy Practices

I, ___________________________ hereby affirm that a copy of the *Notice of Privacy Practices* from **Georgia Eye Partners** has been presented to me and a copy is available upon request. Under federal law 104-191, known as HIPAA, I am entitled to receive a copy of this *Notice* from my healthcare provider.

My signature below also affirms the information I have provided is factual and accurate. My signature also signifies that I have been presented with a copy of the *Notice of Privacy Practices* but does not legally bind or obligate me in any way.

I voluntarily consent to evaluation and treatment from the physicians and staff at GEP. I am aware that the practice of medicine is not an exact science and no guarantees have been made regarding the results of treatment or examinations by GEP. I consent to the use and disclosure of protected health information about me for treatment, payment and operations.

____ ______________________________
Signature of Patient or Legal Guardian Date Name of Patient or Legal Guardian

GEORGIA EYE PARTNERS

Patient Health History Questionnaire

Todays Date ____________________

Patient Name ____________________

Date of Birth ____________________

Referring Doctor ____________________

Reason for visit:

____

Do you take any prescribed or over the counter eye drops? ☐ Yes ☐ No

Please list all eye drops: ____________________

Have you received the flu vaccine within the last 12 months? ☐ Yes ☐ No Pneumococcal Vaccine? ☐ Yes ☐ No

Do you wear glasses/contact lenses or both? ☐ Yes ☐ No Contacts ☐ Soft ☐ Hard

Do you have or have been previously treated for any of the following health conditions:

Cataracts ☐ No ☐ Yes (please explain) ____________________
Cornea Disease ☐ No ☐ Yes (please explain) ____________________
Crossed/"lazy" Eye ☐ No ☐ Yes (please explain) ____________________
Diabetic Eye Disease ☐ No ☐ Yes (please explain) ____________________
Dry Eye ☐ No ☐ Yes (please explain) ____________________
Eye Injury ☐ No ☐ Yes (please explain) ____________________
Glaucoma ☐ No ☐ Yes (please explain) ____________________
Macular Degeneration ☐ No ☐ Yes (please explain) ____________________
Retinal Tear ☐ No ☐ Yes (please explain) ____________________
Retinal Detachment ☐ No ☐ Yes (please explain) ____________________
Abnormal Bleeding ☐ No ☐ Yes (please explain) ____________________
Arthirits ☐ No ☐ Yes (please explain) ____________________
Cancer ☐ No ☐ Yes (please explain) ____________________
Diabetes ☐ No ☐ Yes Controlled? ☐ No ☐ Yes by: ☐ Diet ☐ Pills ☐ Insulin
Gastrointestinal ☐ No ☐ Yes (please explain) ____________________
HIV/AIDS ☐ No ☐ Yes (please explain) ____________________
High Blood Pressure ☐ No ☐ Yes (please explain) ____________________
Heart Attack ☐ No ☐ Yes (please explain) ____________________
Heart Disease ☐ No ☐ Yes (please explain) ____________________
Kidney Disease ☐ No ☐ Yes (please explain) ____________________
Liver Disease ☐ No ☐ Yes (please explain) ____________________
Stroke ☐ No ☐ Yes (please explain) ____________________
Other ☐ No ☐ Yes (please explain) ____________________

Are you pregnant or breastfeeding? ☐ No ☐ Yes Due Date ____________________

Have you ever had surgery on your eye(s)? ☐ No ☐ Yes, please list all surgeries with dates & doctor below:

____

____

Please list all other surgeries with dates and surgeon name: ☐ None

____

____

____

List all other medications including any over-the-counterand prescription. Include dosage and frequency:
☐ None

____________________________________ ________________________________

____________________________________ ________________________________

____________________________________ ________________________________

Are you allergic to any medications? ☐ No ☐ Yes If Yes, please list all allergies and reactions:

____

____

Has anyone in your family has any of the following? If yes, please list relationship:

Cataracts	☐ No	☐ Yes	Who? __________________________
Cornea Disease	☐ No	☐ Yes	Who? __________________________
Crossed/"lazy" Eye	☐ No	☐ Yes	Who? __________________________
Glaucoma	☐ No	☐ Yes	Who? __________________________
Macular Degeneration	☐ No	☐ Yes	Who? __________________________
Retinal Tear	☐ No	☐ Yes	Who? __________________________
Retinal Detachment	☐ No	☐ Yes	Who? __________________________
Diabetes	☐ No	☐ Yes	Who? __________________________
Other	☐ No	☐ Yes	Who? __________________________

Social History

Do you smoke? ☐ Never ☐ Yes, _____ pack/day ☐ Former Smoker, quit date _____________

Alcohol Use? ☐ No ☐ Yes

If Yes ☐ 3 or less drinks per week ☐ 4 or more drinks per week

Review of Systems Are you currently experiencing any problems?

Constitution (weight gain, loss of appetite, other)	☐ No	☐ Yes	______________________
Cardiovascular (chest pain, irregular rhythm, other)	☐ No	☐ Yes	______________________
Ear, Nose, Mouth (dryness, sore throat, runny nose, earache)	☐ No	☐ Yes	______________________
Respiratory (shortness of breath, wheezing, cough, other)	☐ No	☐ Yes	______________________
Gastrointestinal (constipation, diarrhea, acid reflux, other)	☐ No	☐ Yes	______________________
Genitourinary (painful urination, incontinence, other)	☐ No	☐ Yes	______________________
Musculoskeletal (joint pain/swelling, muscle ache)	☐ No	☐ Yes	______________________
Integumentary (skin rash, itching, other)	☐ No	☐ Yes	______________________
Neurological (headache, dizziness, other)	☐ No	☐ Yes	______________________
Psychiatric (anxiety, depression, other)	☐ No	☐ Yes	______________________
Endocrine (frequent urination, frequent thirst, other)	☐ No	☐ Yes	______________________
Hematologic/Lymphatic (anemia, excessive bleeding)	☐ No	☐ Yes	______________________
Allergic/Immunologic (hay fever, itchy eyes, other)	☐No	☐ Yes	______________________

Height: _____________ Weight ____________

GEORGIA EYE PARTNERS

OPAL aesthetics

Patient Financial Responsibility Agreement

In order for us to provide our patients with quality medical care, we must receive payment for our services. This document explains the patient's obligations in regards to financial responsbility for services rendored.

In exchange for services rendered, each patient or patient's guarantor agrees to:

- Authorize payment of surgical and medical benefits to Georgia Eye Partners (GEP), which would otherwise be payable to you. If covered by Medicare or Medicaid, I certify that the information provided by me in applying for payment and titles V, XVII, and/or XIX of the Social Security Act is correct.

- Pay all non-covered charges (including refraction), co-pays, co-insurance, deductible, and out-of-network charges at the time of service.

    - Refraction Fee: $40.00.
    - Cancellation Fee: $40.00 Applied for failure to provide a 24 hour cancellation notice
    - Contact Lens Fitting Fee: This fee varies depending on the type of contact lens you request or the type of lenses necessary to provide you the best possible vision. The fee is collected in addition to the fee for an eye examination.

- Provide a copy of your most recent insurance card, other proof of insurance and/or register with the receptionist at the time of EACH visit. If you do not provide us with valid insurance information at the time of EACH visit, and your insurance company subsequently denies our claim, you will be responsible for any and all charges.

- Obtain any authorization or referral required by your insurance plan and/or from your Primary Care Physician prior to each appointment. If you do not receive the required authorization and insurance does not pay for services rendered, you will be responsible for any and all charges. Additionally, we may need to reschedule your visit if you do not have your authorization or referral.

In the event we must refer the patient's account to a collection agency or attorney for collection of an amount 90 days or older, the patient and/or guarantor agrees to pay our collection fee, including any accrued interest and all applicable bank fees incurred for a returned check.

As the patient or guarantor of a patient, I agree that in consideration of the services rendered by GEP, I am individually obligated to pay for all services in accordance with the regular rates, terms and conditions of GEP.

As a courtesy to our self-pay patients seeking routine eye care, GEP will provide a reduced charge if services are paid in full at time of rendering. Once you accept the discount, we will not be responsible for filing claims to any insurance company nor will we accept payment from any insurance company. In the event we receive an insurance payment under these circumstances, we will refund the money to the insurance company.

I have read this form and have had the opportunity to ask questions and my questions have been answered. By my signature, I represent that I have voluntarily read, understand and agree to be bound by the above provisions.

____ ______________________________

Patient or Guarantor - Signature Date