"Where Your Vision Is Our Mission"

Patient Registration

Patient's First Name: _____
Patient's Middle Name: _____
Patient's Last Name: _____
Sex: ☐Female ☐Male
Date of Birth: _____
Social Security Number: _____ - ____ -_____
Address: _____
City, State and Zip Code: _____
Home Phone Number: _____ - _____ - _____
Mobile Phone Number: _____ - _____ - _____
Work Phone: _____ - _____ - _____
Email: _____ @ _____
Primary Care Physician's Name: _____
Primary Care Physician's Phone #: _____ - _____ - _____
Pharmacy Name & Address: _____
_____
Were you referred by any doctor? ☐ Yes ☐ No
If so, please print the name and phone number below:
_____

Emergency Contact
Name: _____
Relationship: _____
Phone #: _____ - _____ - _____

Primary Insurance Information
Insurance Plan Name: _____
Member ID No: _____
Group No: _____
Policy Holder (if other than patient)
Last Name: _____
First Name: _____
_____
Sex: ☐Female ☐Male
Relationship to Patient: _____

Secondary Insurance Information
Insurance Plan Name: _____
Member ID No: _____
Group No: _____
Policy Holder (if other than patient)
Last Name: _____
First Name:

Sex: ☐Female ☐Male
Relationship to Patient: _____

_____ _____
Patient's Signature Date

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"Where Your Vision Is Our Mission"

What brings you into the office today?

☐ Comprehensive, Dilated Eye Exam	☐ Diabetic Eye Exam	☐ Visual Disturbance
☐ Lasik Consultation	☐ Eye Injury / Infection	☐ Chalazion (Stye)
☐ Glasses / Contact Lens Prescription	☐ Contact Lens Evaluation	☐ Dry Eye
☐ Cataract Evaluation	☐ Glaucoma Evaluation	☐ Retinal Problem

Medical History:

Are you currently being treated for any medical conditions? ☐ Yes ☐ No

If yes, please explain:

Have you had any eye surgeries in the past? ☐ Yes ☐ No

If yes, please explain:

Are you currently taking any medications? ☐ Yes ☐ No

(Including oral contraceptives and Over the Counter):

Please list all:

If you have a list, please present it to the receptionist

Are you allergic to any substances or medications? ☐ Yes ☐ No

If yes, please list all and reactions:

Are you currently pregnant or nursing? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ Former ☐ No

Eye History:

·When was your last eye exam? _____ ·Prev. Eye Doctor's Name: _____

·Do you wear glasses? _____ ·Do you wear contacts? _____

·How often do you wear glasses/contacts? ☐ Constantly ☐ Reading Only ☐Distance Only ☐ Rarely

Please note any information you think we should know about, not listed or described above:

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Assignment and Release:

I hereby assign my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for all non-covered services, copays, deductibles and/or coinsurance. I authorize and give consent for my provider to bill me directly for recommended services performed that are not covered under the terms of my health plan. I authorize the physician to release and medical information required to process this claim. I authorize my provider's office to contact me by telephone to remind me of my appointments.

Signature: _____ Date: _____

Cancellation Policy:

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Please understand that we set aside appointment times for each patient in which we do not double book our patients. Please be informed that starting November 1, 2017, there will be a $50.00 fee for NO SHOW appointments. This fee must be paid in full before you are seen again. This fee is not covered by your insurance company. We apologize for any inconvenience but hope that you understand that we want the best care for all our patients.

Signature: _____ Date: _____

Refraction Fees:

A refraction is a diagnostic service Dr. Nissirios and Dr. Kajoshaj perform to make sure you have a proper and correct prescription for your future glasses or contact lenses. The fee is $50.00 for each and is due at the time of service. Unfortunately, most insurance carriers do not deem this service as medically necessary and therefore consider it a non-covered service.

If you have the following insurance plans stated below, please disregard this message.
(These specific insurance carriers do cover refraction fees.)

- ·Most HIP Plans
- ·United Healthcare Community Plan
- ·Healthcare Partners
- ·BCBS POS - MTA
- ·Davis Vision/Spectera

Signature: _____ Date: _____

We accept cash, all major credit/debit cards and checks.
Checks will be payable to: MetroEyeMD