PUNZAL VISION

Patient Registration Form

Patient Information

Last: _____ **First:** _____ **Middle:**_____

Title: Mr.☐ Ms.☐ Mrs.☐ Dr.☐ **Nickname (or preferred name):** _____

Address: _____ **Apartment #:** _____

City, State, Zip: _____ **Date of Birth**: _____/_____/_____

Gender: ☐F ☐M **Marital status:** _____ **SSN (last 4 needed for VSP members)**_____

Primary Phone Number: _____ **circle one:** Home☐ Cell☐ Work☐

Secondary Phone Number: _____ **circle one:** Home☐ Cell☐ Work☐

Email: _____

Employment of Patient (or guardian)

Employer:_____

Occupation:_____

Work phone:_____

Primary Care Physician

Full Name:_____

Phone:_____

Address:_____

Spouse (or emergency contact) Information

Name_____

Employer:_____DOB:_____

Occupation:_____ Phone:_____

Whom may we thank for sending you to our clinic?

Referred by Dr._____

Referred by: ☐Patient ☐Friend ☐Yellow Pages ☐Internet

☐Newspaper Ad ☐TV Ad ☐Radio Ad Other:_____

Health Insurance information

	Insurance Company	Subscriber Name	Relation	Subscriber #	Subscriber Birthdate
Primary	_____	_____	_____	_____	____/____/____
Secondary	_____	_____	_____	_____	____/____/____
Other	_____	_____	_____	_____	____/____/____

If Workers Comp - please fill out additional form available from check-in desk.

IMPORTANT INFORMATION – PLEASE READ & SIGN BELOW

YOUR EYES MAY BE DILATED FOR YOUR EXAM.

Dilating drops are used to enlarge the pupils to allow your doctor to get a better view of the inside of your eye. These drops can cause light sensitivity, glare, and blurred vision, and rarely an acute angle-closure glaucoma.

DARK GLASSES ARE REQUIRED.

If you do not have your own, please ask us for a pair. It is not possible for your doctor to predict how much your vision will be affected. Driving may be difficult immediately after an examination. Although most people do not have difficulty driving with dilated eyes and sunglasses, it may be best if you make arrangements not to drive yourself.

Patient (or Guardian's) Signature_____**Date:**_____

PUNZAL VISION

Financial & Insurance Information Sheet

Our goal is to provide each patient with the finest medical care in a professional environment which inspires trust and confidence. Our office is a business that must be managed efficiently, if we are to continue serving our patients with quality care. Our fees are fair and reflect the care and expertise with which we treat each patient. To keep our fees from rising considerably and to minimize the expenses of billing and bookkeeping, we offer our patients payment options.

Punzal Vision is a medically-driven optometric practice; therefore, as a standard, we run all screening tests on our patients in order to provide optimal care. Insurance will not be billed for these tests unless there are diagnoses to justify billing the insurance(s). These screening tests enable us to detect pathology of which we may not otherwise be aware.

We ask that all estimated co-payments be paid upon check in, unless other arrangements have been made. Patients with no insurance coverage and out-of-state patients must pay in full for services before leaving the clinic. Payment for spectacles and contact lenses must be paid in full in order to process orders.

Please note that **Medicare** and some other insurers limit the number of services or visits for which they will pay. **They do not cover routine eye exams and any part of the exam that includes "refraction".** If Medicare will not cover these services, you are responsible for payment. Please present ALL insurance cards to the receptionist so that we may make copies for our files.

We accept payment with cash, personal check, credit card, or Paypal. We understand that you may have medical insurance to cover your services. However, in the event of non-covered services, deductibles, co-payments, insurance cancellations, etc., you can pay with your credit / debit card. Payment plans are also available through this office.

SIGNATURE REQUIRED - Please read carefully and sign below

- My signature below on this form constitutes a signature on file. This enables Punzal Vision and its physicians to submit insurance claims for benefits on my behalf without obtaining my signature.
- I understand and agree that I am responsible for the payment of all treatment fees on my account. If my insurance company fails to make payment or denies any services, I will be responsible for the full amount owed. A photocopy of this assignment is as valid as the original.
- In the event that a collection agency or attorney has to be used to collect the amounts I owe Punzal Vision, I agree that I will be responsible for all costs incurred to collect from me using those services.
- I understand that there is a $25 fee for returned checks.

Patient (or Guardian's) Signature_____**Date:**_____

PUNZAL VISION

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT & HEALTHCARE OPERATIONS

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

SIGNATURE REQUIRED - Please read carefully and sign below

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice may request and use your prescription medication history from other healthcare providers or third-party pharmacy benefit payors for treatment purposes
- The Practice may submit prescriptions for medications electronically to the patient's pharmacy in a secure fashion
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this consent

Patient (or Guardian's) Signature_____**Date:**_____

MEANINGFUL USE DEMOGRAPHIC QUESTIONNAIRE

Punzal Vision is participating in the Government sponsored "Meaningful Use" program, and is therefore asked to collect the following information from each patient. Please place only **one** check mark for each question below:

1. Language you prefer to speak?

- ☐ English
- ☐ Japanese
- ☐ Chinese
- ☐ Ilocano
- ☐ Hawaiian
- ☐ Spanish
- ☐ Other _____

2. Ethnicity?

- ☐ Non-Hispanic
- ☐ Hispanic

3. Race?

- ☐ Asian or Asian American
- ☐ Caucasian or European American
- ☐ Hawaiian or other Pacific Islander
- ☐ African or African American
- ☐ Native American or Native Alaskan

4. Smoking

- ☐ Current every day smoker
- ☐ Current some day smoker
- ☐ Never smoker
- ☐ Former smoker
- ☐ Unknown if ever smoked

PUNZAL VISION

Patient Health History

Primary Care Physician: _____ Date Last Seen: _____

Medications (Prescription, over the counter, vitamins/supplements):

_____

_____

Allergies to Medicines: _____

Eye Surgeries: _____

Existing Eye Conditions: _____

Surgeries: _____

Please indicate if any of the conditions apply to a family member (blood relatives only).

			Relation				Relation
Diabetes	Y☐	N☐	_____	Macular Degeneration	Y☐	N☐	_____
Hypertension	Y☐	N☐	_____	Glaucoma	Y☐	N☐	_____
Stroke	Y☐	N☐	_____	Retinal Detachment	Y☐	N☐	_____
				Eye Turn (Strabismus)	Y☐	N☐	_____

Review of Systems Please indicate below if you have or ever had problems with the following conditions:

Allergic/Immunologic	Ear, Nose, and Throat	Gastrointestinal	Skin/Integumentary	Psychiatric
▫ None	▫ None	▫ None	▫ None	▫ None
▫ Lupus (SLE)	▫ Sinusitis	▫ Crohn's Disease	▫ Eczema	▫ Depression
▫ Rheumatoid Arthritis	▫ Upper Respiratory	▫ Colitis	▫ Rosacea	▫ Bi-polar
▫ Environmental Allergies	☐ Tract Infection	▫ Acid reflux/Ulcer	▫ Psoriasis	▫ Schizophrenia
▫ Seasonal Allergies	▫ Other	▫ Other	▫ Other	▫ Other
▫ Other _____				

Cardiovascular	Endocrine/Glands	Respiratory	Muscle/Skeletal	Genital/Urinary
▫ None	▫ None	▫ None	▫ None	▫ None
▫ High Blood Pressure	▫ Diabetes	▫ Asthma	▫ Arthritis	▫ Urinary Tract Infection
▫ Heart Disease	▫ Hormone Dysfunction	▫ Bronchitis	▫ Fibromyalgia	▫ HIV Positive
▫ Stroke	▫ Thyroid Dysfunction	▫ Emphysema	▫ Anklosing Spondylitis	▫ Herpes/Chlamydia
▫ Vascular Disease	▫ Other	▫ Other	▫ Other	▫ Other

Hematologic/Lymphatic	Neurological	General Health	Social
▫ None	▫ None	▫ None	▫ None
▫ Anemia	▫ Multiple Sclerosis	▫ Weight loss/gain	☐ Current Smoker ☐ Former Smoker
▫ Leukemia	▫ Epilepsy	▫ Fever	▫ Narcotic Use (Illicit Drugs) _____
▫ Bleeding Disorder	▫ Tremors	▫ Fatigue	▫ Alcohol Consumption _____
▫ Other	▫ Other	▫ Trauma	▫ Weight _____ Height _____

For Females: Are you pregnant? Y☐ N☐ Are you breastfeeding? Y☐ N☐

Please sign below to acknowledge that this form is current:

Signature: _____ Print Name: _____ Date: _____