Advanced Eye Care, SC
Patient Registration Form

(Please print and complete all entries.)

Patient Name (First-MI-Last) | Date of Birth | Age | Circle Marital Status
Single Married Divorced Widow

Parent/Guardian (if patient is a minor or dependant) First-MI-Last | Relationship

Street Address | Home Phone | Cell Phone

City-State-Zip | Social Security Number | ☐ Male ☐ Female

Employer | Occupation | Work Number

Employer's Address

Spouse's Name | Date of Birth | Social Security Number

Spouse's Employer | Employer's Phone Number

Please tell us how you heard about our office?

☐ Health Plan ☐ Telephone Book ☐ Website ☐ Referred By: _____

Who is financially responsible for payment? | Responsible Party's phone number

Insurance Information

Primary Insurance Company | Address | Phone Number

Subscriber | Relationship | Social Security Number | Date of Birth

Secondary Insurance Company | Address | Phone Number

Subscriber | Relationship | Social Security Number | Date of Birth

Pharmacy Information

Pharmacy Name: _____ Phone: _____

Pharmacy Address: _____

Referring Physician

Primary Care or Referring Physician | Primary Care Physician Phone Number

I certify to the best of my knowledge that the above information is correct and true. I hereby authorize release of information necessary to file a claim with my insurance company. I understand I am financially responsible for all professional services provided and for any balance not covered by my insurance carrier.

Signature: _____ Date: _____

Advanced Eye Care SC

Authorization for Medical/Surgical Treatment

I consent to office care encompassing routine technical procedures and medical treatments performed by my attending physician, assistant, or designees, as may be necessary in my physician's best medical judgment.

Consent for Release and Use of Confidential Information and Receipt of Notice of Privacy Practices

I hereby give my consent to Advanced Eye Care SC to use or disclose, for the purpose of carrying out treatment, payment, and health care operations, all information contacted in the patient record of _____.

I acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved a right to change his or her privacy practices that are described in this Notice. I also understand that a copy of any revised Notice will be made available at my next visit following the revision.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied upon it to use or disclose my heath information. Written revocation of consent must be sent to the physician's office.

Signed: _____ Date: _____

Parent/Guardian: _____

Advanced Eye Care SC
HIPAA Form
(Please print and complete all entries)

Patient Name: _____ Date of Birth: _____

I hereby give my consent to Advanced Eye Care SC, it's physicians and staff, to provide medical information as follows:

____ Do not give any health information to anyone other than me.

____ You may give health information to the following person(s):

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship

_____ You may leave health information on the answering machine or voice mail at the number listed below:

Home Phone: _____

Work Phone: _____

Cell Phone: _____

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time giving written notice of my desire to do so to the physician's office. I also understand that I will not be able to revoke this consent in cases where the physician or staff has already relied on it to use or disclose my health information.

Signature of Patient/Guardian: _____

Date: _____

Advanced Eye Care, SC
Medicare Coverage Statement

(Please print and complete all entries.)

Medicare has many strict guidelines regarding your eye exam. If you are seeing one of our physicians for a routine eye exam, and you are not having any medical problems, Medicare will not pay for your visit. Consequently, incurred charges will become your responsibility. Under Section 1862(a)(1) Title XVIII of the Social Security Act, Medicare pays only for services that are determined to be "reasonable and necessary." Refraction (CPT 92015) is NOT reimbursed by Medicare. Our fee is currently $45.00 and will be your responsibility.

Beneficiary Agreement

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Advanced Eye Care SC for any services furnished to me by Advanced Eye Care SC. I authorize any holder of medical information to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

Name (Please Print): _____

Signature: _____ Date: _____

Advanced Eye Care SC	#207887
	#207893
Dr. Patricia Davis	#539140

ADVANCED EYE CARE, SC

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I am a patient of Advanced Eye Care SC. I hereby acknowledge receipt of the Practice's Notice of Privacy Practices.

Name [please print]: _____

Signature: _____

Date: _____

OR

I am a parent or legal guardian of _____ [patient name]. I hereby acknowledge receipt of the Practice's Notice of Privacy Practices with respect to the patient.

Name [please print]: _____

Relationship to Patient: ☐ Parent ☐ Legal Guardian

Signature: _____

Date: _____

Advanced Eye Care

1870 Silver Cross Blvd. | Suite 110
New Lenox, IL 60451
815.485.2727

DIRECTIONS:

From the North (off I-55): Take I-55 South to I-355 South. Exit at Rt. 6 / Southwest Highway and turn right. Turn left onto Silver Cross Boulevard. Turn left at Entrance 3 and proceed to 1870 Silver Cross Boulevard / Pavilion B.

From the South (off I-55): Take I-55 North to I-80 East. Exit onto I-355 North. Exit at Rt.6 / Southwest Highway and turn right. Turn left onto Silver Cross Boulevard. Turn left at Entrance 3 and proceed to 1870 Silver Cross Boulevard / Pavilion B.

From the East (off I-80): Take I-80 West to I-355 North. Exit at Rt. 6 / Southwest Highway and turn right. Turn left onto Silver Cross Boulevard. Turn left at Entrance 3 and proceed to 1870 Silver Cross Boulevard / Pavilion B.

From the West (off I-80): Take I-80 East to I-355 North. Exit at Rt.6 / Southweast Highway and turn right. Turn left onto Silver Cross Boulevard. Turn left at Entrance 3 and proceed to 1870 Silver Cross Boulevard / Pavilion B.

History and Intake Form

NAME:_____ **DOB:**_____

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Artificial joints
Asthma
Atrial fibrillation
BPH
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Pacemaker
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Valve Replacement
None
Other _____

Past Surgical History: (please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
PTCA
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement within last 2 years
Kidney Biopsy
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP
Skin Biopsy
Basal Cell Cancer Surgery
Squamous Cell Carcinoma Surgery
Melanoma Surgery
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
None
Other _____

Ocular History: (please circle all that apply)

Allergic conjunctivitis
Blepharitis
Cataract (Left eye, Right eye)
Corneal dystrophy (Left eye, Right eye)
Diabetic retinopathy, background (Left eye, Right eye)
Dry eyes
Glaucoma (Left eye, Right eye)
Macular degeneration (Left eye, Right eye)
Macular ERM (Left eye, Right eye)
Narrow angles (Left eye, Right eye)
Ocular hypertension (Left eye, Right eye)
Ophthalmic Migraine
Pseudoexfoliation
Retinal tear (Left eye, Right eye)
Strabismus
PVD (Left eye, Right eye)
Vitrous floaters (Left eye, Right eye)
None
Other _____

Ocular Surgery: (please circle all that apply)

Blepharoplasty (Left eye, Right eye)
Cataract surgery (Left eye, Right eye)
Corneal transplant (Left eye, Right eye)
DSAEK (Left eye, Right eye)
Eye Muscle Surgery
Intravitreal injections (Left eye, Right eye)
LASIK (Left eye, Right eye)
LPI (Left eye, Right eye)
LTP (Left eye, Right eye)
PRK (Left eye, Right eye)
Ptosis repair (Left eye, Right eye)
Punctal plugs (Left eye, Right eye)
Strabismus surgery
Retinal laser (Left eye, Right eye)
Trabeculectomy (Left eye, Right eye)
Tube shunt (Left eye, Right eye)
Yag capsulotomy (Left eye, Right eye)
None
Other _____

Family History: (please circle all that apply and write in who had the disease)

Blindness _____
Cancer _____
Cataracts _____
CVA _____
Diabetes _____
Glaucoma _____
Heart disease _____
Macular degeneration _____
Migraine _____
Retinal detachment _____
Strabismus _____
None

Other _____

Medications: (Please list all current medications)

_____
_____
_____
_____
_____

None

Allergies: (Please enter all allergies)

_____
_____
_____
_____

None

Social History: (Please circle all that apply)

Cigarette Smoking:

- Never smoked
- Quit: former smoker
- Smokes less than daily
- Smokes daily

Illicit Drug Use:

- Drug Use
- IV Drug Use

Alcohol Use:

- Alcohol: none
- Alcohol: less than 1 drink a day
- Alcohol: 1-2 drinks a day
- Alcohol: 3 or more drinks a day

Safety:

- I feel safe at home.
- I do not feel safe at home.

Race/Ethnicity patient information is a requirement for practices using electronic health records.

Race:
White
American Indian
Asian
Black or African American
Pacific Islander
Other

Ethnicity:
Hispanic or Latino
Not Hispanic or Latino

Preferred Language:
English
Other:_____

Your Preferred Pharmacy:

Pharmacy Name: _____

Address: _____ (or street/ major intersection)

City: _____

Review of Systems: Are you currently experiencing any of the following?
(please check yes or no for the following)

Symptom	Yes	No
POOR VISION		
EYE PAIN		
TEARING		
REDNESS		
JAW PAIN		
SCALP TENDERNESS		
AMAUROSIS FUGAX		
LOSS OF VISION		
FEVER		
CHILLS		
WEIGHT LOSS		
COUGH		
DRY MOUTH		
HIGH BLOOD PRESSURE		
RAPID HEART BEAT		
CONGESTION		
WHEEZING		
SHORTNESS OF BREATH		
UPSET STOMACH		
FREQUENT URINATION		
JOINT PAIN		
STIFFNESS		
ARTHRITIS		
RASH		
CHANGING MOLES		
HEADACHE		
SEIZURE		
PARALYSIS		
ANXIETY		
DEPRESSION		
DIABETES		
THYROID ABNORMALITIES		
BLEEDING ANEMIA		
ALLERGIES		
HAY FEVER		
COPD		
EMPHYSEMA		
CORONARY ARTERY DISEASE		
HEARING LOSS OR AIDS		

SINUS PROBLEMS		
GERD		
HIATAL HERNIA		
PSORIASIS		
ECZEMA		
SKIN CANCER		
RHEUMATOID ARTHRITIS		
LUPUS		
CHOLESTEROL		

Alerts: Are you currently experiencing any of the following?
(please check yes or no for the following)

Alert	Yes	No
ALLERGY TO ADHESIVES		
BLOOD THINNERS		
DEFIBRILLATOR		
FLOMAX		
MRSA		
NARROW ANGLES		
PACEMAKER		
PREGNANCY OR PLANNING A PREGNANCY		
PSEUD EXFOLIATION SYNDROME		
STEROID RESPONDER		

Other Symptoms: _____