PATIENT REGISTRATION FORM-Dr. Anil K. Sethi

Last ___________________________

First ____________________ MI ________

Street ___________________________

City ____________________ State ________

Zip Code ___________________________
Home Phone _(____)___________________
Cell Phone _(____)___________________
Work Phone _(____)___________________
Patient's SSN _______________________
Patient's Date of Birth _______________
Sex: M F Age ________________
E-mail ___________________________
Marital Status _______________________
Occupation (or grade)_________________
Employer (or school)__________________
Whom may we contact in case of emergency?

____

We follow the guidelines and provisions as governed by the Health Insurance Portability and Accountability Act (HIPPA). A copy of our Privacy Practice is available in our reception area. Please initial to acknowledge our privacy policy.__________

Any problems with your current glasses and/or contact lenses? ____________________

____

Are you interested in new glasses today? Y N
ASK US ABOUT OUR 2ND PAIR SAME DAY ORDER,
Backup glasses are important, consider a back up pair of readers, distance, or computer glasses, starting at $89 complete.

Are you interested in being fit or refit for contact lenses today?
Y N *Fitting fees apply for contact lenses.

VERY IMPORTANT! NEW PATIENTS ONLY:
Who may we thank for referring you to our office?
Name of friend/relative:__________________

How did you hear about our office? (Check all that apply.)

- ☐ Another Dr. ________________________
- ☐ Insurance List /Website
- ☐ Saw Sign/Building
- ☐ Web page: Which site?________________
- ☐ Other: ____________________________

Please note that routine vision plans do not cover care for medically-related conditions.

Vision Insurance_______________________
Subscriber Name_______________________
Relationship to Patient:_________________
Subscriber SSN or ID#__________________
Subscriber Birth Date___________________
Subscriber's Address: ☐ Same as patient

Primary Medical Insurance_______________
Subscriber Name_______________________
Relationship to Patient:_________________
Subscriber SSN or ID#__________________
Subscriber Birth Date___________________
Subscriber's Address: ☐ Same as patient

Do you participate in a flex spending account?

☐ Yes ☐ No

How will you settle your account today?

☐ Check ☐ Credit Card ☐ Cash

Lifestyle Questions

Do you…

- ☐ work at a computer? How many hours/week?______
- ☐ think you might benefit from thinner, lighter lenses?
- ☐ have an interest in being fitted for the latest contact lens designs?
- ☐ spend time outdoors? How many hours/week?______
- ☐ have prescription sunwear? Y N Polarized? Y N
- ☐ prefer not to wear glasses at times?
- ☐ want information on LASER vision correction surgery?
- ☐ have interest in non-surgical approach to vision correction?
- ☐ have more than one pair of current Rx eyewear?
- ☐ have children? Do your children wear sunglasses? Y N
- ☐ have family members in need of eyecare?

What activities/Sports do you engage in?

- ☐ Auto Repair
- ☐ Biking
- ☐ Boating/water sports
- ☐ Bookkeeping
- ☐ Bowling
- ☐ Computer
- ☐ Tennis/Racquetball
- ☐ Watching TV,movies,sport events
- ☐ Exercise
- ☐ Football
- ☐ Golf
- ☐ Gardening /Landscaping
- ☐ Home/shop/woodwork/carpentry
- ☐ Hunting Shooting
- ☐ Jogging/Running
- ☐ Musical instruments
- ☐ Painting /Drawing
- ☐ Playing cards
- ☐ Pilot/flying/Traveling
- ☐ Welding
- ☐ Reading newspapers/Books
- ☐ Sewing/needle work/crafts
- ☐ Shooting
- ☐ Stamp/coin collecting
- ☐ Swimming/Fishing
- ☐ Snow sports
- ☐ Video Gaming

Office Use :VSP, MES, TRICARE, SPECTERA, DAVIS, EYE MED MEDICARE, MEDI-CAL, B/ CROSS, B/SHIELD, Aetna, Cigna, Culinary, UNITED Other Insurance. *A fee is applied whenever there is less than a 24 hour notice on appointment changes or cancellations. Please initial _____

Medical History Questionnaire

Name: ______________________ Today's Date: ____ / ____ / ____

Address: ______________________ Phone: ______________

City: ______________ Zip: ________ Work Phone: ______________

Guardian (If Applicable): ______________________ Occupation: ______________

Birth Date: ____ / ____ / ____ Social Security #: ____ / ____ / ____ Last Eye Exam: ____ / ____ / ____

Name of Medical Doctor: ______________________ Dr.'s Phone: ______________

Last Medical Exam: ____ / ____ / ____

Medical History

Do you have any allergies to medications? ❒ no ❒ yes If yes, explain: ______________________

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):

____

List all major injuries, surgeries and/or hospitalizations you have had: ______________________

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury: ______________________

Are you pregnant and/or nursing? ❒ no ❒ yes

Do you wear glasses? ❒ no ❒ yes If yes, how old is your present pair of lenses? ______________

Do you wear contact lenses? ❒ no ❒ yes If yes, how old is your present pair of lenses? ______________

Type of contact lenses: ❒ Rigid ❒ Soft ❒ Extended Wear ❒ Other Are they comfortable? ❒ yes ❒ no

Family History

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	❒	❒	❒	
Cataract	❒	❒	❒	
Crossed Eyes	❒	❒	❒	
Glaucoma	❒	❒	❒	
Macular Degeneration	❒	❒	❒	
Retinal Detachment/Disease	❒	❒	❒	
Arthritis	❒	❒	❒	
Cancer	❒	❒	❒	
Diabetes	❒	❒	❒	
Heart Disease	❒	❒	❒	
High Blood Pressure	❒	❒	❒	
Kidney Disease	❒	❒	❒	
Lupus	❒	❒	❒	
Thyroid Disease	❒	❒	❒	
Other ______________	❒	❒	❒	

✳ *Please turn this form over and complete side two* ✳

Social History

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

❐ Yes, I would prefer to discuss my Social History information directly with my doctor. (Check box)

Do you drive? ❐ no ❐ yes If yes, do you have visual difficulty when driving? ❐ no ❐ yes If yes, please describe:

____

Do you use tobacco products? ❐ no ❐ yes If yes, type/amount/how long: ____________________

Do you drink alcohol? ❐ no ❐ yes If yes, type/amount/how long: ____________________

Do you use illegal drugs? ❐ no ❐ yes If yes, type/amount/how long: ____________________

Have you ever been exposed to or infected with: ❐ Gonorrhea ❐ Hepatitis ❐ HIV ❐ Syphilis

Review of Systems

Do you currently, or have you ever had any problems in the following areas:

SYSTEM	NO	YES	?
CONSTITUTIONAL			
Fever, Weight Loss/Gain	❐	❐	❐
INTEGUMENTARY (Skin)	❐	❐	❐
NEUROLOGICAL			
Headaches	❐	❐	❐
Migraines	❐	❐	❐
Seizures	❐	❐	❐
EYES			
Loss of Vision	❐	❐	❐
Blurred Vision	❐	❐	❐
Distorted Vision/Halos	❐	❐	❐
Loss of Side Vision	❐	❐	❐
Double Vision	❐	❐	❐
Dryness	❐	❐	❐
Mucous Discharge	❐	❐	❐
Redness	❐	❐	❐
Sandy or Gritty Feeling	❐	❐	❐
Itching	❐	❐	❐
Burning	❐	❐	❐
Foreign Body Sensation	❐	❐	❐
Excess Tearing/Watering	❐	❐	❐
Glare/Light Sensitivity	❐	❐	❐
Eye Pain or Soreness	❐	❐	❐
Chronic Infection of Eye or Lid	❐	❐	❐
Sties or Chalazion	❐	❐	❐
Flashes/Floaters in Vision	❐	❐	❐
Tired Eyes	❐	❐	❐
ENDOCRINE			
Thyroid/Other Glands	❐	❐	❐

	NO	YES	?
EARS, NOSE, MOUTH, THROAT			
Allergies/Hay Fever	❐	❐	❐
Sinus Congestion	❐	❐	❐
Runny Nose	❐	❐	❐
Post-Nasal Drip	❐	❐	❐
Chronic Cough	❐	❐	❐
Dry Throat/Mouth	❐	❐	❐
RESPIRATORY			
Asthma	❐	❐	❐
Chronic Bronchitis	❐	❐	❐
Emphysema	❐	❐	❐
VASCULAR / CARDIOVASCULAR			
Diabetes	❐	❐	❐
Heart Pain	❐	❐	❐
High Blood Pressure	❐	❐	❐
Vascular Disease	❐	❐	❐
GASTROINTESTINAL			
Diarrhea	❐	❐	❐
Constipation	❐	❐	❐
GENITOURINARY			
Genitals/Kidney/Bladder	❐	❐	❐
BONES / JOINTS / MUSCLES			
Rheumatoid Arthritis	❐	❐	❐
Muscle Pain	❐	❐	❐
Joint Pain	❐	❐	❐
LYMPHATIC / HEMATOLOGIC			
Anemia	❐	❐	❐
Bleeding Problems	❐	❐	❐
ALLERGIC / IMMUNOLOGIC	❐	❐	❐
PSYCHIATRIC	❐	❐	❐

If you answered YES to any of the above or have a condition not listed, please explain & list medications:

____

____

____

____

____

______________________ Doctor's Signature

______________________ Date

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Eye Care Crisp Vision Optometry-Statement of Patient Financial Responsibility

Patient Name:____________________________________ DOB:______________________

We appreciate the confidence you have shown in choosing us to provide for your eye care needs. The service you have elected to participate in, implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we accept most insurance plans, and will bill your insurance carrier on your behalf. However, you are ultimately responsible for the payments on your account.

You are responsible for any deductibles, and co-payment/coinsurance as determined by your contract with your insurance carrier. It is our responsibility to bill your insurance in a timely manner, and bill remaining balances to you, also in a timely manner.

We thank you for the confidence and trust you have put in this practice.

I have read the above policy regarding my financial responsibility to Eye care Crisp Vision Optometry- Dr . Anil K. Sethi, for providing services to me. I certify that the information I have provided is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Eye care Crisp Vision Optometry-Dr. Anil K. Sethi, the full and entire amount of my bill incurred by me, or if applicable, any amount due after payment has been made by my insurance carrier.

Patient Signature: ____

Guarantor Signature: ______________________________________

(If Patient is a minor)

Co-Pay Policy:

Some health insurance companies require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the service is rendered. Co-pays are due at EACH VISIT. Thank you for your cooperation of this matter.

Patient/Guarantor Signature: ______________________________

Consent for Treatment and Authorization to Release Information:

I hereby authorize Eye care Crisp Vision Optometry, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.

I fully authorize Eye care Crisp Vision Optometry, to release to appropriate agencies, any information required in the course of my or the above named patient's examination and treatment.

Patient/Guarantor Signature: ______________________________

Cancellation/No Show Policy:

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24 hours prior to your appointment. We often have a wait list for Saturday appointments, and you may incur a fee, without providing 24 hour cancellation notice.

If you no show for three consecutive appointment, you may be released from our care. We treat chronic conditions, and follow up appointments are key to your successful treatment. The practice will notify you, in writing, via Certified Mail, if you are discharged from our care.

Patient/Guarantor Signature: ______________________________

Self-Pay:

I do not have health insurance, or vision coverage, and will be responsible for services rendered here at Eye care-Crisp Vision Optometry. I agree to pay Eye care Crisp Vision Optometry-Dr. Anil K. Sethi, the full and entire amount of treatment given to me or to the above named patient, at each visit.

Patient/Guarantor Signature: ______________________________