Beach Eye Medical Group
REGISTRATION AND MEDICAL HISTORY

1 PATIENT INFORMATION

Patient _____

Last 4 SS#: _____

Address _____

City/State/Zip _____

Preferred Method of Contact:
Home or / Cell#:_____

Age _____ Birth Date: _____ Sex ☐M ☐F

Email: _____

☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

Race:_____ Ethnicity:_____

Preferred Language:_____

Occupation: _____

Spouse's Name _____

Primary Care Physician _____

REASON FOR VISIT: Medical _____ Vision _____

Explanation: _____

Who can we Thank for referring you to us?

_____

2 INSURANCE

Person responsible for account?_____

Relationship to Patient _____

Insurance Co_____

Subscriber's Name _____

Birth Date_____

Subscriber ID _____ Group#: _____

CONFIDENTIALITY & BENEFITS: ASSIGNMENT & RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage and assign directly to Beach Eye Medical Group. All insurance benefits to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that my records are confidential and my signature authorizes the doctor to release all information necessary for the purpose of health care, insurance operations and to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____

Relationship _____Date_____

EMERGENCY CONTACT (Please specify someone who does not live in your household)

Name_____ Relationship _____

Home Phone_____ Work Phone _____

3 NEW PATIENT EYE HEALTH HISTORY

Eye Doctor _____

Date of Last Visit _____

Date of Last Eye Exam _____

Do You Wear Glasses?

☐ Not at all ☐ All the time ☐ Occasionally

☐ Reading ☐ Driving ☐ TV ☐ _____

Do You Wear Contact Lenses?

☐ Never ☐ Not any more ☐ Occasionally

Type_____ Hrs/Day_____

Describe any problems you have with your contacts: _____

Check to indicate if you have had any of the following:

☐ Blindness	☐ Dry Eyes	☐ Macular Degeneration
☐ Bloodshot Eyes	☐ Eye Infection	☐ Migraine Headaches
☐ Blurred Vision,Distance	☐ Eye Injury	☐ Night Vision, Poor
☐ Blurred Vision,Near	☐ Eye Strain	☐ Red Eyes
☐ Burning Eyes	☐ Fainting Spells/Blackouts	☐ Retinal Detachment
☐ Cataracts	☐ Floaters or spots	☐ Seeing Halos
☐ Color Vision – Poor	☐ Glaucoma	☐ Seeing Flashes
☐ Crossed Eyes	☐ Headaches	☐ Temporary Vision Loss
☐ Discharge from Eyes	☐ Itching Eyes	☐ Turned Eye
☐ Dizzy Spells	☐ Lazy Eyes	☐ Twitching Eyelid
☐ Double Vision	☐ Loss of Vision	☐ Watering Eyes

☐ Other_____

List any and all eye surgeries (including lasers): _____

4 INFORMATION REGARDING DILATING EYE DROPS

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye. Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it's best if you make arrangements not to drive yourself.

Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention. I hereby authorize Beach Eye Medical Group to administer dilating eye drops if necessary. I understand I have the opportunity to use sunglasses provided by Beach Eye Medical Group after my office visit.

_____ _____

Patient (or person authorized to sign for patient) Date

5 HEALTH HISTORY

Check Box to indicate if you have had any of the following:

- ☐ AIDS HIV
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Bleeding
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Diabetes
- ☐ Drug Sensitivity
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Hay Fever
- ☐ Heart Condition
- ☐ Hepatitis (Type _____)
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Lupus
- ☐ Migraine Headaches
- ☐ Pacemaker
- ☐ Rheumatic Fever
- ☐ Shingles
- ☐ Skin Condition
- ☐ Stroke
- ☐ Thyroid Conditions
- ☐ Tuberculosis

Other Medical Problems (not listed already)

_____
_____
_____
_____
_____
_____
_____

Past Surgical History (except eye)

_____
_____
_____
_____
_____

Check if a blood relative has had any of the following:

	Relationship to you
☐ Blindness	_____
☐ Cataracts	_____
☐ Diabetes	_____
☐ Glaucoma	_____
☐ Retinal Detachment	_____

Technician Signature: _____

Personal/Social History

Are You Pregnant? _____ Number of Children _____

Tobacco Use _____ Alcohol Use _____

☐ **NO CHANGE SINCE _____ INITIAL _____**

MEDICATIONS

List medications you are currently taking, including eye drops:

☐ No Medications ☐ Taking Aspirin

_____
_____
_____

☐ **NO CHANGE SINCE _____ INITIAL _____**

Pharmacy Name & Phone #: _____

ALLERGIES

List your allergies to medications or other substances:

_____
_____
_____
_____

☐ **NO CHANGE SINCE _____ INITIAL _____**

☐ **NO ALLERGIES**

6 INSURANCE AUTHORIZATION

I request that payment of authorized Medicare benefits be made to me or on my behalf to Beach Eye Medical Group.
for any services furnished me by their doctor. I authorize any holder of medical information about me to release to Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer of agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier. As per office policy a fee of **$50** will be made to your account for all checks returned from the bank. Thank you for allowing us to take care of your eyes.

By Signing this, I _____, acknowledge my financial responsibility as described above and
(Patient Name / Person Financially Responsible)
have provided the above information today.