

Patient Registration



Email Address _____ Date _____
 Last Name _____ First Name _____
 Home Address _____ City _____ State _____ Zip _____
 Home Phone _____ Work Phone _____ Ext _____
 Birth date _____ Age _____ Social Security no.(if needed to access your benefits) _____
If under 18 y.o., Parent/Guardian Name & DOB _____
 Sex: M F Marital Status: Single Married Other _____
 Employer/Occupation: _____ Employment Status: Employed Student Other _____
 Work Address _____ City _____ State _____ Zip _____
 Primary Care Physician _____ Referred by _____

Assignment & Release - I, the undersigned, certify that I (or my dependent) have insurance coverage as stated below (in insurance information section) and assign directly to Dr. Abundo all insurance benefits and payable to Dr. Abundo for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I agree to pay all interest charges, collection fees, and/or attorney fees/court costs of 40% of the delinquent balance if placed with a collection agency. I understand there is a \$25.00 service charge for all returned checks. I understand that appointments not cancelled prior to appointment time may be subject to a \$25.00 missed appointment fee.

Responsible Party Signature: _____ Relationship: _____ Date: _____

Receipt of Privacy Practice Acknowledgement - I hereby acknowledge that a copy of *Abundo Eye Care's* Notice of Privacy Practices was provided to me. I further acknowledge and understand that if I have any questions about *Abundo Eye Care's* privacy practices or my rights with regard to my personal health information, I may contact *Abundo Eye Care's* contact person for further information as set forth in the Notice.

Responsible Party Signature: _____ Relationship: _____ Date: _____

Primary Insurance Insured = Policy Holder	Insurance Name _____ Relationship to patient _____
	Insured's ID No. _____ Group ID No. _____
	Insurance Address _____ City _____ State _____ Zip _____
	Insurance Phone _____ Date effective _____
	Enter Insured's Name & Address if not self from above:
	Insured's Last Name _____ First Name: _____
	Insured's Address _____ City _____ State _____ Zip _____
	Insured's Home Phone _____ Insured's Work Phone _____
	Insured's Birth date _____ <input type="checkbox"/> Male <input type="checkbox"/> Female
	Insured's Employer _____ Plan Name or Program Name _____
	Employment Status <input type="checkbox"/> F/T <input type="checkbox"/> P/T <input type="checkbox"/> Not Employed <input type="checkbox"/> Self-Employed <input type="checkbox"/> Retired <input type="checkbox"/> Active Duty <input type="checkbox"/> Unknown
	Insured's Employer Address _____
Secondary Insurance	Insurance Name _____ Relationship to patient _____
	Insured's ID No. _____ Group ID No. _____
	Insurance Address _____ City _____ State _____ Zip _____
	Insurance Phone _____ Date effective _____
	Enter Insured's Name & Address if not self from above:
	Insured's Last Name _____ First Name: _____
	Insured's Address _____ City _____ State _____ Zip _____
	Insured's Home Phone _____ Insured's Work Phone _____
	Insured's Birth date _____ <input type="checkbox"/> Male <input type="checkbox"/> Female
	Insured's Employer _____ Plan Name or Program Name _____
	Employment Status <input type="checkbox"/> F/T <input type="checkbox"/> P/T <input type="checkbox"/> Not Employed <input type="checkbox"/> Self-Employed <input type="checkbox"/> Retired <input type="checkbox"/> Active Duty <input type="checkbox"/> Unknown
	Insured's Employer Address _____

Medical History



Patient name _____ Date _____ I decline to be dilated _____ (Initials)

Emergency contact name _____ Emergency contact phone no. _____

When was your **LAST EYE EXAM** _____ What would you change about your current glasses? _____

List medications you are **ALLERGIC** to _____

List your **MEDICATIONS** _____

List any **SURGERIES** you had _____

Do you smoke? No Yes, & how many years _____

Drink alcohol? No Yes, & how much? _____

Family history:

High blood pressure..... Relation _____

Glaucoma.....Relation _____

Diabetes.....Relation _____

Cataracts.....Relation _____

CancerRelation _____

Macular Degeneration.....Relation _____

Other _____ Relation _____

Retinal Problems.....Relation _____

Personal Medical History or symptoms you have with these systems:

Allergic/Immunologic _____

Cardiovascular _____

Ear/Nose/Mouth/Throat _____

Endocrine _____

Eyes _____

Gastrointestinal _____

Genitourinary _____

Blood/Lymph _____

Skin _____

Musculoskeletal _____

Neurological _____

Psychiatric _____

Respiratory _____

Other symptoms _____

Work on a computer? No Yes & how many hours/day? _____

Are you sensitive to?: reflective glare sunlight bright light conditions fluorescent lights

Do your eyes get: dry or red Under what conditions? _____

Laser Eye Surgery

Have you had Laser vision correction? No Yes When? _____

Are you interested in knowing if you are a candidate for laser vision correction? No Yes

Contact Lens Wearers

What would you change about your current contact lenses? _____

Brand/name of contacts you wear _____ Name of cleaning solution you use _____

You replace your contacts how often? _____ How often are they supposed to be changed? _____

Do you sleep with your contacts in your eyes? No Yes How many nights do you sleep with them? _____

Have you had any eye infections or eye ulcers while wearing contacts? No Yes

Have you had any damage to your eyes while wearing contacts? No Yes and state the problem _____

Additional comments _____