

TUCKER VISION CENTER

TERRY L. TUCKER, O.D.

88 Pine Island Road, Suite #3
North Fort Myers, FL 33903

Phone: 239.656.1778

Fax: 239.656.5858

NEW PATIENT REGISTRATION

PATIENT'S LAST NAME _____ FIRST _____ MI _____

Purpose of Visit: _____

Is it Work Related? Y / N

Parents Information (if child is a minor)

| | | | | | | | |
|---|----------------------------|---------------|----------------|--------------------|----------------------------|---------------|----------------|
| LAST NAME OF PATIENT | | FIRST | MI | LAST NAME (PARENT) | | FIRST | MI |
| PERMANENT ADDRESS | | | MARITAL STATUS | PERMANENT ADDRESS | | | MARITAL STATUS |
| CITY | STATE | ZIP | SEX | CITY | STATE | ZIP | SEX |
| HOME PHONE | WORK PHONE | DATE OF BIRTH | | HOME PHONE | WORK PHONE | DATE OF BIRTH | |
| SOCIAL SECURITY # | DRIVERS LICENSE / STATE ID | AGE | | SOCIAL SECURITY # | DRIVERS LICENSE / STATE ID | AGE | |
| EMPLOYED BY/SCHOOL | ADDRESS | | | EMPLOYED BY | ADDRESS | | |
| CITY | STATE | ZIP | TELEPHONE | CITY | STATE | ZIP | TELEPHONE |
| OCCUPATION | E-MAIL ADDRESS | | | OCCUPATION | E-MAIL ADDRESS | | |
| NAMES AND AGES OF ALL FAMILY MEMBERS LIVING IN HOME | | | | | | | |

REFERRED BY

| | | |
|---|---------|-----------|
| REFERRAL NAME | ADDRESS | TELEPHONE |
| <input type="checkbox"/> YELLOW PAGES <input type="checkbox"/> NEWSPAPER <input type="checkbox"/> RADIO <input type="checkbox"/> OTHER NAME OF REFERRAL SOURCE | | |

NEAREST RELATIVE NOT LIVING AT ABOVE ADDRESS

| | | | | |
|-----------|-------|----|---------|-----------|
| LAST NAME | FIRST | MI | ADDRESS | TELEPHONE |
|-----------|-------|----|---------|-----------|

INSURANCE

| | | | | | | | |
|--|-------------------|---------------|-----|--|-------------------|---------------|-----|
| NAME OF PRIMARY INSURANCE COMPANY | | | | NAME OF SECONDARY INSURANCE COMPANY | | | |
| ADDRESS | | | | ADDRESS | | | |
| CITY | STATE | ZIP | | CITY | STATE | ZIP | |
| <input type="checkbox"/> CHECK HERE IF THE RESPONSIBLE PARTY IS THE INSURED PARTY. IF NOT COMPLETE BELOW | ID NO. | GROUP NO. | | <input type="checkbox"/> CHECK HERE IF THE RESPONSIBLE PARTY IS THE INSURED PARTY. IF NOT COMPLETE BELOW | POLICY NO. | GROUP NO. | |
| NAME OF INSURED PARTY | | D.O.B. | SEX | NAME OF INSURED PARTY | | D.O.B. | SEX |
| RELATIONSHIP TO PATIENT | SOCIAL SECURITY # | TELEPHONE NO. | | RELATIONSHIP TO PATIENT | SOCIAL SECURITY # | TELEPHONE NO. | |
| ADDRESS | CITY | STATE | ZIP | ADDRESS | CITY | STATE | ZIP |

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NAME _____ AGE _____

| PRIMARY CARE PHYSICIAN | | |
|------------------------|-----------|-----|
| NAME | PHONE NO. | |
| ADDRESS | | |
| CITY | STATE | ZIP |
| DATE OF LAST CHECK-UP | | |

| EYE HISTORY | |
|---|----------------------------|
| DATE OF LAST EXAM | DOCTOR |
| CURRENTLY WEAR CONTACT LENSES? | WHAT BRAND/TYPE? |
| SOLUTIONS USED | EVER TRIED CONTACT LENSES? |
| SATISFIED WITH VISION/COMFORT OF CURRENT EYEWEAR? | |

| PRESENT MEDICATIONS | | | |
|---------------------|------------------|------|------------------|
| NAME | DOSAGE/FREQUENCY | NAME | DOSAGE/FREQUENCY |
| | | | |
| | | | |
| | | | |
| | | | |

| LIFESTYLE QUESTIONS | |
|------------------------------------|---|
| PLEASE CHECK ONLY THOSE THAT APPLY | |
| <input type="checkbox"/> | Work on a computer all day |
| <input type="checkbox"/> | Work on a computer for some of the day |
| <input type="checkbox"/> | Think you might benefit from a thinner, lighter lense |
| <input type="checkbox"/> | Have an interest in contacts |
| <input type="checkbox"/> | Spend a lot of time outdoors |
| <input type="checkbox"/> | Have prescription sunwear |
| <input type="checkbox"/> | Prefer not to wear your glasses at times |
| <input type="checkbox"/> | Have a back up pair of Rx glasses |
| <input type="checkbox"/> | Do you Smoke? Yes No |

| FAMILY MEDICAL HISTORY | | |
|------------------------------------|------------------|---------------|
| PLEASE CHECK ONLY THOSE THAT APPLY | Mother's side | Father's side |
| <input type="checkbox"/> | Hypertension | |
| <input type="checkbox"/> | Blindness | |
| <input type="checkbox"/> | Cataracts | |
| <input type="checkbox"/> | Corneal problems | |
| <input type="checkbox"/> | Diabetes | |
| <input type="checkbox"/> | Glaucoma | |
| <input type="checkbox"/> | Heart Disease | |
| <input type="checkbox"/> | Lazy Eye | |
| <input type="checkbox"/> | Macular Problems | |

| MEDICAL HISTORY | | | | | |
|--|---------------------|--------------------------|-----------------------------|--------------------------|-------------------------|
| HAVE YOU EVER BEEN DIAGNOSED OR TREATED FOR THE FOLLOWING HEALTH PROBLEMS? | | | CHECK ONLY THOSE THAT APPLY | | |
| <input type="checkbox"/> | ALLERGIES | <input type="checkbox"/> | WEIGHT LOSS/GAIN | <input type="checkbox"/> | BLURRY VISION |
| <input type="checkbox"/> | BLOOD/LYMPH | <input type="checkbox"/> | ARTHRITIS | <input type="checkbox"/> | BURNING |
| <input type="checkbox"/> | CANCER | <input type="checkbox"/> | BRONCHITIS | <input type="checkbox"/> | CATARACTS |
| <input type="checkbox"/> | DIABETES | <input type="checkbox"/> | CHOLESTEROL | <input type="checkbox"/> | CROSSED EYED/TURNED |
| <input type="checkbox"/> | EAR/NOSE/THROAT | <input type="checkbox"/> | DIGESTIVE | <input type="checkbox"/> | EYE INFECTIONS |
| <input type="checkbox"/> | ECZEMA/RASHES | <input type="checkbox"/> | ENDOCRINE | <input type="checkbox"/> | FLASH OF LIGHT |
| <input type="checkbox"/> | FEVERS | <input type="checkbox"/> | FATIGUE | <input type="checkbox"/> | GLAUCOMA |
| <input type="checkbox"/> | HIGH BLOOD PRESSURE | <input type="checkbox"/> | GENITOURINARY | <input type="checkbox"/> | HEADACHES |
| <input type="checkbox"/> | KIDNEY | <input type="checkbox"/> | INTEGAMENTORY | <input type="checkbox"/> | ITCHINESS |
| <input type="checkbox"/> | NEUROLOGICAL | <input type="checkbox"/> | MUSCLE/BONE | <input type="checkbox"/> | MACULAR DEGENERATION |
| <input type="checkbox"/> | RESPIRATORY | <input type="checkbox"/> | SINUS | <input type="checkbox"/> | RETINAL DETACHMENT |
| <input type="checkbox"/> | THROAT INFECTIONS | <input type="checkbox"/> | THYROID | <input type="checkbox"/> | TEARING |
| | | | | <input type="checkbox"/> | UNCOMFORTABLE |
| | | | | <input type="checkbox"/> | BURNING |
| | | | | <input type="checkbox"/> | CORNEAL ABRASION |
| | | | | <input type="checkbox"/> | DOUBLE VISION |
| | | | | <input type="checkbox"/> | EYE INJURY |
| | | | | <input type="checkbox"/> | FLOATERS/SPOTS |
| | | | | <input type="checkbox"/> | GRITTIENESS |
| | | | | <input type="checkbox"/> | IRITIS/UVEITIS |
| | | | | <input type="checkbox"/> | LAZY EYE |
| | | | | <input type="checkbox"/> | OCCASIONAL DRYNESS |
| | | | | <input type="checkbox"/> | SUNLIGHT SENSITIVITY |
| | | | | <input type="checkbox"/> | TROUBLE SEEING AT NIGHT |
| | | | | <input type="checkbox"/> | OTHER |

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ACKNOWLEDGEMENT FORM

I understand that, under the Health Insurance Portability and Accountability Act (HIPPA), I have certain rights to privacy regarding my protected health information (Our Notice of Privacy Practices). I understand that this information can and will be used to conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly and to obtain payment from third-party payers. I understand that I have the right to review and receive a copy of this Notice before signing this form.

I understand that I may revoke this authorization at any time by submission in writing. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

By signing below, I acknowledge that I have read and understand the terms of this authorization. I hereby knowingly and voluntarily authorize Tucker Vision Center (Terry L. Tucker, O.D.) to use or disclose my health information in the manner described above.

Please print your name here

Signature

Witness

Tucker Vision Center is hereby authorized to discuss my protected healthcare information with the individuals below:

Name: _____

Name: _____

Name: _____

**Authorization for Release of Information
And
Assignment of Benefits for Medicare
& Other Insurance Providers**

I request that payment of authorized Medicare benefits/Other Insurance Providers be made on my behalf to Terry L. Tucker, O.D. (Tucker Vision Center), for any services provided to me by the physician or supplier. I authorize any holder of medical information about me to release to Medicare and its agents any information needed to determine these benefits payable for related services.

I understand that my physician and/or its staff will not release any information to my family members or me without verification of my/their identity in order to comply with privacy regulations. I also understand that information will be released to other healthcare professionals for the coordination of my care/treatment and/or health insurance carriers in the event that it's necessary to process a claim.

By my signature, I state that I have read, understand, and agree to this authorization and release.

Signature

Date

Medigap Authorization

I authorize any holder of medical or other information about me to release information needed for this or a related Medigap claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to either myself or to the party who accepts assignment.

Signature

Date

Policy Number

TUCKER VISION CENTER

FINANCIAL POLICY

Please Read Carefully

In non-participating plans, the guarantor is responsible for the difference of usual and customary allowances. In participating plans, the guarantor is responsible for balances as per explanations from the individual's insurance company.

We request that you make payment for all co-payments, deductibles, and office services at the time of your visit. Any unpaid balances after insurance has paid are expected to be paid within 90 days.

Failure to make payment in full as stated above or failure to make other financial arrangements for payment will result in your account being placed with a collection agency. You can be charged collection and/or attorney fees that may affect your credit. Accounts sent to collections will be charged a 1.5% interest fee per month after 30 days.

We are always available to assist you to collect from your insurance or make payments on your account balance. Your help and cooperation is necessary and appreciated.

I recognize that it is my responsibility to understand my insurance plan and keep Tucker Vision Center informed of any changes.

Patient/Guarantor Signature

Date