Patient Registration

Name (Last):_____ (First):_____(Middle):_____
Address:_____
City:_____State:_____Zip:_____Country:_____
Birth Date:_____ Phone: Home: (___)_____Work: (___)_____
Cell: (___)_____
Contact By: __Phone __Mail __Cell Preferred Language:_____ Sex: __ Male __ Female

Marital Status: __ Single __ Married __ Divorced __ Widowed SSN: _____
__ Separated __ Civil Union __Other: _____
Race: __ American Indian or Alaska Native __ Asian __ Black or African American
__ Native Hawaiian or Pacific Islander __ White __ Other race
__ More than one race __ Declined/Not available

Ethnicity: __ Hispanic/Latino __ Non-Hispanic/Latino __ Declined/Not available

Employment Status (mark all that apply): __ Full-time __ Part-time __ Self-employed __ Retired
__ Student __ Child __ Unemployed __ Other:_____

Primary Care Provider: _____ Phone: _____
Preferred Pharmacy: _____ Phone: _____
Emergency Contact: _____ Phone: _____

Responsible Party (Party responsible for payment): __ Self __ Spouse __ Parent __ Other: _____
Name (Last):_____ (First):_____(Middle):_____
Address:_____
City:_____State:_____Zip:_____Country:_____
Birth Date:_____ Phone: Home: (___)_____Work: (___)_____
Cell: (___)_____ Sex: __ Male __ Female
Fax: (___)_____ Email: _____ SSN: _____

Primary Insurance: _____ Effective Date: _____
Insured Party: __ Self __ Spouse __ Parent __ Other: _____ ID#: _____ Group#: _____
Subscriber Name (Last): _____(First):_____ DOB:_____

Secondary Insurance: _____Effective Date: _____
Insured Party: __ Self __ Spouse __ Parent __ Other: _____ ID#: _____ Group#: _____
Subscriber Name (Last): _____(First):_____ DOB:_____

_____ _____ __/__/____ _____
Signature of Patient or Representative Relationship to Patient Date Time

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Interpretation: The information presented orally to the patient/ representative/ decision maker was interpreted into (language): _____. The person for whom the information was interpreted stated s/he understood the interpretation

_____ _____
Interpreter Name Agency and ID# (if applicable)

_____ _____ __/__/____ _____
Staff Signature/ Title Print Name or ID# Date Time

PATIENT HISTORY RECORD

PLEASE ANSWER THE FOLLOWING QUESTIONS: IF THE ANSWER IS YES, PLEASE BREIFLY EXPLAIN IN THE SPACE PROVIDED

1. Have you ever been treated for any medical conditions? (DIABETES, HIGH BLOOD PRESSURE, ARTHRITIES) ____ YES ____ NO

_____

2. Have you ever had any eye diseases? (GLAUCOMA, CATARACT, RETINAL DETACHMENT) ____ YES ____ NO

_____

3. Do you take any medications? ____ YES ____ NO…. IF YES, PLEASE FILL OUT MEDICATION LIST (NEXT PAGE)
4. Do you have ANY allergies to mediations or food? ____ YES ____ NO

_____

5. Do you take any EYE medications? ____ YES ____ NO.... IF YES, PLEASE ENTER MEDICATIONS ON MEDICATION LIST (NEXT PAGE)

REVIEW OF SYSTEMS

DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING PROBLEMS: IF YES, PLEASE BRIEFLY EXPLAIN.

Chronic Fever, Unexpected weight loss/gain, Fatigue? ____ YES ____ NO

_____

Ear/Nose Throat (Hearing loss, hearing aide, Sinus, Sore throat) ____ YES ____ NO

_____

Heart problems (Chest pains, Irregular heart beat) ____ YES ____ NO

_____

Respiratory problems (Shortness of breath, Wheezing, Coughing) ____ YES ____ NO

_____

Gastrointestinal problems (Diarrhea, Vomitting, Abdominal pain) ____ YES ____ NO

_____

Skin problems, Joint pain, Muscle aches, Numbness, Weakness ____ YES ____ NO

_____

MEDICATION LIST

NAME: _____ DOB: _____
ALLERGIES (include reactions): _____
No Known Drug Allergies (please circle): Yes / No

DATE	MEDICATION/DOSAGE	FREQ.	PRESCRIBED BY	DISC. DATE	NOTES

OVER THE COUNTER

HERBALS / ALTERNATIVE

PHARMACY: _____ TEL #: _____

STEFAN S. O'CONNOR, M.D.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

I,_____ have received a copy of this office's Notice of Privacy Practices.

_____

Signature Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

____Individual refused to sign

____An emergency situation prevented us from obtaining acknowledgement

____Other (please specify)

_____

Financial Agreement

THANK YOU FOR CHOOSING STEFAN S. O'CONNOR, M.D. FOR YOUR FAMILY EYE CARE. WE ARE PLEASED TO WELCOME YOU TO OUR PRACTICE. OUR MAIN CONCERN IS THAT YOUR FAMILY RECEIVES OPTIMAL CARE FOR MAINTAINING HEALTHY VISION. OUR FINANCIAL POLICY IS AS FOLLOWS AND PLEASE FEEL FREE TO DISCUSS THIS WITH OUR BILLING DEPARTMENT AT ANY TIME. WE ARE HERE TO PROVIDE THE BEST HEALTH CARE. PLEASE COMLETE ALL INSURANCE INFORMATION, READ OUR FINANCIAL POLICY AND SIGN BELOW TO VERIFY THE RECEIPT OF THIS INFORMATION. WE UNDERSTAND THAT OCCASIONALLY SOME OF OUR PATIENTS WILL EXPEREINECE SOME FINANCIAL DIFFICULTIES. IT IS OUR HOPE THAT YOU WILL BRING THESE PROBLEMS TO THE ATTENTION OF OUR BILLING DEPARTMENT OR THE OFFICE MANAGER TO ALLOW US TO MANAGE YOUR ACCOUNT. PLEASE BE ADVISED THAT YOUR INSURNACE COMPANY IS A CONTRACT BETWEEN YOU AND YOUR EMPLOYER. WE ARE HAPPY TO SUBMIT CLAIMS FOR PAYMENT, HOWEVER, THE FINAL RESPONSIBILITY FOR MONEY OWED BELONGS TO THE PATIENT OR GURANTOR.

1. WE ACCEPT CASH, CHECK, VISA OR MASTERCARD
2. YOUR COPAYMENT AND SELF-PAYMENT AMOUNTS ARE DUE AT THE TIME OF THE VISIT
3. YOUR FINANCIALLY RESPONSIBLE FOR ALL MONEY NOT PAID BY YOUR INSURANCE CARRIER
4. MEDICARE DOES NOT PAY FOR REFRACTIONS, AND THIS ($30.00) IS DUE AT THE TIME OF THE VISIT
5. IF WE DO NOT PARTICIPATE WITH YOUR INSURANCE, PAYMENT IS DUE AT THE TIME OF VISIT
6. PATIENTS NEEDING REFERRALS WILL NOT BE SEEN WITHOUT THEIR REFERRAL. YOU MUST CALL YOUR PRIMARY CARE PHYSICIAN PRIOR TO YOUR APPOINTMENT
7. RETURNED CHECKS ARE SUBJECT TO $20.00 SERVICE CHARGE
8. IT IS YOUR RESPONSIBILITY TO ADVISE OUR OFFICE IF YOU ARE BEING SEEN AS PART OF A VISION BENEFIT PACKAGE PROVIDED BY YOUR EMPLOYER (INSURANCE USUALLY COVERED EVERY OTHER YEAR)
9. WE ARE HAPPY TO PROVIDE ANY COUNSELING ON OUR BILLING PRACTICES. HOWEVER, IF YOUR ACCOUNT IS NOT PAID WITHIN 60 DAYS YOU WILL BE RESPONSIBLE FOR PAYMENT
10. IF WE ARE PARTICIPATING WITH YOUR INSURANCE COMPANY WE ARE UNDER CONTACT TO ADJUST YOUR ACCOUNT BY A CERTAIN AMOUNT, WHICH IS KNOWN AS "CONTRACTUAL WRITE-OFF." THIS DOES NOT MEAN THAT YOU WILL NOT HAVE A BALANCE. WE WILL BILL FOR THE MONEY AS DIRECTED BY YOUR INSURANCE COMPANY
11. ANY ACCOUNT THAT GOES TO COLLECTIONS WILL BE RESPONSIBLE FOR ANY PRECENTAGE OF DEBT, LEGAL OR COURT COSTS AS SPECIFIED BY OUR COLLECTION SERVICES
12. YOUR SIGNATURE ON THIS PAGE SIGNIFIES THAT YOU ACCEPT AND ACKNOWLEDGE THE ABOVE INFORMATION. THIS ALSO SERVES AS AN ASSIGNMENT OF INSURANCE BENEFITS PAID DIRECTLY TO STEFAN S. O'CONNOR M.D. P.A. YOU WILL ALSO GIVE PERMISSION TO RELEASE INFORMATION TO YOUR INSURANCE COMPANY OR ATTORNEY RELEVANT TO THE CARE YOU RECEIVED FROM STEFAN S. O'CONNOR M.D.

DR. O'CONNOR WOULD LIKE TO THANK YOU FOR CHOOSING OUR OFFICE AS YOUR FAMILY EYE CARE PROVIDER. WE APPRECIATE YOUR TRUST AND THE OPPORTUNITY TO SERVE YOU AND YOUR FAMILY.

PATIENT OR GURANTOR SIGNATURE:_____**DATE:**_____