New Patient Registration

Please fill out this form so we can know you better!

Atlantic Eye Center

PERSONAL INFO

PATIENT NAME		DOB:	Appt Date & Time
Local Mailing Address		SSN:	
City/State/Zip Code		Home Phone #	
Alternate Address		Cell Phone #	
City/State/Zip Code		Sex ☐ Male ☐ Female	Marital Status M D S W
Retired? ☐ Y ☐ N	Employer	Spouse's Name	
Occupation		Referred by	
Preferred Language		Email Address	
ETHNICITY: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino	RACE: ☐ White/Caucasian ☐ Black/African American ☐ Native American/Alaska Native ☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐ Other:		
Emergency contact (other than spouse): Relationship Phone #		Do you give permission to AEC to advise family members of medical status? Relationship Phone #	INITIAL

MINOR

IF THE PATIENT IS A MINOR, PLEASE FILL OUT THE FOLLOWING INFORMATION.

A minor is defined as any patient who is under the age of 18. The person bringing the minor in to the appointment is responsible for the account, regardless of custody and/or insurance policy holder information. (Must bring custody papers or notarized permission notice if other than parent.)

Responsible Adult Name	Date of Birth	Sex M F
Relationship	Social Security #	
Address if different from above	Mother's Name	Phone #
City/State/Zip Code	Father's Name	

INSURANCE INFORMATION

Atlantic Eye Center participates with Medicare and many other insurance networks. It is ultimately the patient's responsibility to ensure network participation with the insurance company. AEC cannot assume responsibility for network participation. Please provide a photo ID and insurance cards to receptionist.

Primary Insurance Co.	Policy Holder (if other than patient)
Policy Number	Relationship to Patient
Group Number	Date of Birth
Secondary Insurance Co.	Policy Holder (if other than patient)
Policy Number	Relationship to Patient
Group Number	Date of Birth

I certify the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to be released to the Social Security Administration or its intermediaries/carriers for any related Medicare or other insurance claim. I request the payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician/organization furnishing the services or authorize such physician/organization to submit a claim to Medicare or other insurance for payment to me. We file clams to Medicare and most insurance plans. As a courtesy, we will file secondary insurances. If the payment is not received within ninety days, you will be billed. If incorrect insurance information is provided to us, we will be unable to file a claim after 90 days from the date of service. All professional services are the patient's responsibility regardless of insurance coverage. You are expected to pay for any DEDUCTIBLES, CO-PAYMENTS, & NON-COVERED SERVICES at the time of service. We accept cash, checks, Visa, MasterCard, Discover, and American Express. I verify the information provided is true and accurate. I understand it is my responsibility to notify AEC of any changes to the information provided.

SIGNATURE

SIGNATURE _____ DATE _____

RELATIONSHIP (if other than patient) _____ REASON (if unable to sign) _____

Medical History

It's important that we learn your history!

Atlantic Eye

PATIENT NAME	DATE OF BIRTH

PCP / PHARMACY

MEDICAL DOCTOR'S First & Last Name	Address
	Phone Number
Date Last Seen	Fax Number
PHARMACY NAME	Address
	Phone Number
	Fax Number

MEDICAL HISTORY

Allergies to Medications Y or N

If yes, please list reaction:

Please list all major operations or hospital admissions including eye surgeries and lasers with approximate dates.

PROCEDURE	DATE	PROCEDURE	DATE

Please list ALL MEDICATIONS including eye drops and herbal supplements. Name strength and dose. If you are using eye drops, write down how often you take the drops and which eye. If Medication list is attached, please check here. ☐

MEDICATION	HOW OFTEN	MEDICATION	HOW OFTEN

FAMILY

FAMILY HISTORY (please circle & list relationship)

Blindness	Y	N	Macular Degeneration	Y	N
Glaucoma	Y	N	Other Hereditary Disease	Y	N
Cataracts	Y	N			

SOCIAL

SOCIAL HISTORY (please circle)	DO YOU?		
Drink alcohol?	Y	N	How often?
Smoke tobacco?	Y	N	How often?
Have a history of drug abuse?	Y	N	Explain
Drive?	Y	N	How often?
Have visual difficulties driving?	Y	N	Explain
Have problems with night vision?	Y	N	Explain
Wear glasses?	Y	N	How old is present RX?
Wear contacts?	Y	N	How old is present RX?

REVIEW OF SYSTEMS: Do you currently or have you ever had problems in the following areas? (Please circle & explain)

EARS / NOSE / THROAT			
Hay Fever / Other	Y	N	
Sinuses	Y	N	

CARDIOVASCULAR			
Angina / Chest Pain	Y	N	
Atrial Fibrillation (Afib)	Y	N	
Congestive Heart Failure	Y	N	
Coronary Artery Disease	Y	N	
Heart Attack	Y	N	
Heart Failure / Other	Y	N	
Heart Murmur	Y	N	
Heart Valve Problems	Y	N	
High Blood Pressure	Y	N	
High Cholesterol	Y	N	

RESPIRATORY / LUNG			
Asthma	Y	N	
Emphysema	Y	N	
COPD	Y	N	

GASTROINTESTINAL			
Reflux / Stomach Ulcer	Y	N	
Colitis / Other	Y	N	
Crohn's Disease	Y	N	

ENDOCRINE			
Diabetes	Y	N	☐ Type I
A1C _____			☐ Type II
Last Blood Sugar _____			☐ Insulin
			☐ Non-Insulin
Liver Disease	Y	N	
Thyroid Disease	Y	N	

NEUROLOGIC			
Dementia	Y	N	
Headache	Y	N	
Memory Disorder	Y	N	
Multiple Sclerosis	Y	N	
Neuropathy	Y	N	
Parkinson's Disease	Y	N	
Seizures	Y	N	
Stroke	Y	N	

PSYCHIATRIC			
ADHD	Y	N	
Anxiety / Other	Y	N	
Autism	Y	N	
Bipolar	Y	N	
Claustrophobia	Y	N	
Depression	Y	N	
Schizophrenia	Y	N	

BLEEDING DISORDERS			
Anemia	Y	N	
Blood Transfusion	Y	N	
Coumadin Use	Y	N	
Easy Bruising	Y	N	
Other Blood Thinner	Y	N	

IMMUNOLOGIC			
AIDS	Y	N	
Fibromyalgia	Y	N	
Hepatitis C	Y	N	
HIV	Y	N	
Lupus / Other	Y	N	
Rheumatoid Arthritis	Y	N	

OTHER			
Cancer	Y	N	
Arthritis	Y	N	
Gout	Y	N	
Hearing Loss	Y	N	
Hiatal Hernia	Y	N	
Melanoma	Y	N	
Osteoporosis	Y	N	

OTHER ILLNESSES NOT LISTED

AEC POLICIES

Atlantic Eye Center

HIPAA POLICY

I acknowledge I have received access notification to the modified HIPAA privacy practices, security, enforcement, and breach notification rules under the Health Information Technology for Economic and Clinical Health Act and the Genetic Information Nondiscrimination Act for Atlantic Eye Center.

Initial

AEC REFRACTION POLICY

In Ophthalmology, the refraction is a clinical test used to determine the eye's refractive error and the best corrective lenses to be prescribed. This is a necessary part of the medical exam to provide the sharpest, clearest vision. In most cases, the refraction is required for continuation of care. The refraction fee is $55 and may not be covered by your insurance company (including Medicare).

Initial

DILATING EYE DROP INFORMATION:

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 the 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 the ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it is 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 medical attention. I authorize AEC to administer dilating eye drops which are necessary to diagnose my condition.

Initial

CONSENT TO MEDICAL TREATMENT & PROCEDURES

The undersigned consents to medical treatment, as may be deemed necessary or advisable to the judgment of the Atlantic Eye physician; which may include but is not limited to laboratory procedures, special testing, examination, photography, medical treatment or procedures, or other services rendered to the patient under the general and special instructions of the patient's physician.

Initial