

REGISTRATION FORM

Patient					
Last Name		First Name			
		Zip Code			
Home Phone: ()		Cell Phone: ()			
Emergency Contact numb	er	Contact Name			
Social Security Number:		Date of Birth: Gender:			
E-mail Address:		Referred by:			
Occupation:		Work Number: ()			
Pharmacy Name:		Phone: ()			
Primary care Physician:					
Address:					
Phone Number:		Fax:			

ASSIGNMENT OF PAYMENT

I request that payment of authorized ______ benefits be made ______

On my behalf to Dr. Pisacano/ Dr. Sweeny for services furnished to me by this physician. I authorize any holder of medical information about me to release to the health care financing administration and its agents any information needed to determine these benefits of the benefits payable for related services.

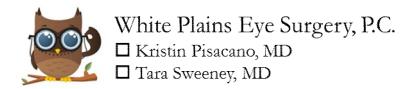
ADDENDUM:

We are happy to participate in your insurance plan and to accept assignment of the charges. This means that we will accept the amount the insurance company approves as our charge and will only bill the difference remaining between what they approve and what they pay.

The exceptions to this rule are for procedures not covered by your insurance companies such as refractions and examinations specifically for Myopia, Presbyopia, Hyperopia, Astigmatism, Headaches and the Fitting of Contact Lenses.

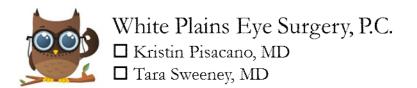
If refraction is performed (check for glasses) the fee of \$ 40.00 is not covered by most insurance companies unless you have an eye care rider.

I understand that I am responsible for the payment of the refraction, contact lens fitting or lenses and for any co-pay or deductible my insurance company does not pay.



Name:	_DOB:	Date:	
PAST OCULAR HISTORY: Previous History of eye treatment or exams:			
Allergies to medications:			
Medication: (Please list current Medications)			
Do you have any problem with the following Eyes:		Please mark yes or no. Cardiovascular:	
Yes	No	Yes	No
Decreased vision at distance \Box		Hypertension	
Decreased vision at near $\hfill\square$		Heart attack 🗆	
Distorted vision \Box		Irregular heart beat 🗆	
Flashing Lights \Box		Pacemaker 🗆	
Floaters		Bypass graft 🗆	
Glare/light sensitivity $\hfill\square$		Chest Pains 🗆	
Night blindness \Box			
Pain or soreness □		Endocrine:	
Styes or chalazion \Box		High Blood Sugar 🛛	
Cataract		Low Blood Sugar	
Glaucoma		Diabetes	
Retinal disorder		Insulin 🗆	
Strabismus (crossed eyes) $\hfill\square$		Pills	
Chronic infection of eye or lid $\hfill\square$		Thyroid disorder	
Allergy/ Immunology:	_	Psychiatric:	
Seasonal allergies		Mood Swing \Box	
Anaphylactic reaction		Depression	
Do you smoke? (Y/N) How much?			•
To you drink alcohol? (Y/ N) How much?			•••
amily History: Yes	No	Unknown	
Iacular Degeneration 🛛			
Diabetes			

Glaucoma.....



NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. 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.
- Obtain payment form third-party payers.
- Conduct normal healthcare operation such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privace Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name			
Relationship to Patient	Self /	Parent /	Other
Signature			
Date			

I hereby give my permission for the doctor to discuss my medical information with the following people:

1.	
2.	
3.	
4.	