DOMINION™
EYE ASSOCIATES
An AVP Company

Patient Registration

Please review, make necessary changes and supply any missing information.

Patient Name		Salutation	Mr. Mrs. Miss Ms.
Date of Birth			
Sex		SS #	
Address			
City, State		Zip code	

Patient Communication					
Pref. Contact Method			Cell Home Work Email Text US Mail		
Home Phone #		Work Phone #		Extension	
Cell Phone #		Email			

Information			
Marital Status		Primary Care Provider	
Occupation		Employer	

Account Responsible							
Responsible		Date of Birth					
Relationship		SS #					
Address							
Home Phone #		Work Phone #		Extension			
Email							

Primary Insurance			
Carrier Name		Group Name	
ID #		Group #	
Address			
Phone			
Insured		Date of Birth	

Secondary Insurance			
Carrier Name		Group Name	
ID #		Group #	
Address			
Phone			
Insured		Date of Birth	

Emergency Contact					
First		Middle		Last	
Relationship		Home#		Cell#	
Work#					

Release Of Medical Information - Status		
Name	Relationship	Release Status

I authorize and request examination by the physicians and staff of Dominion Eye Associates including optometrists and ophthalmic technicians. I authorize the performance of whatever procedures the judgment of the above-named staff may deem necessary during treatment. I also authorize the administration of any anesthetics and analgesics, including eye drops, which the above staff deem advisable. I may request that any procedure not be performed. I authorize payment directly to Dominion Eye Associates of the insurance benefits otherwise payable to me for their services. I also authorize them to provide information to my insurance company directly pertaining to relevant claims. I understand that I may be charged and I agree to pay a fee for forms completion, medical records, collection agency or attorneys' fees pertaining to my account. By my signature below, I acknowledge that I have received the Dominion Eye Associates Notice of Privacy Practices.

Patient Signature: ___________________________ DATE: __________________

Witness Signature: ___________________________ DATE: __________________

Parent/Legal Representative: __________________ DATE: __________________

Insurance Fact Sheet for Non-Medicare Patients

Name: (please print)____

Address: ____

Telephone #: ____

(home) (work) (cell)

1. Please circle any issues you are currently having:

Itchy Eyes ***Dry Eyes*** ***Red Eyes*** ***Eye Pain*** ***Watery Eyes***

Difficulty reading small print ***Difficulty driving at night*** ***Glasses don't fit or work as well***

Double Vision ***Problems with glare*** ***Can't see fine lines*** ***Floaters***

Tired of wearing glasses ***Eye Strain*** ***Change in Vision*** ***Headaches***

Swollen Eyelids ***Droopy Eyelids*** ***"Laugh Lines"*** ***"Crow's Feet"***

2. Do you currently wear contact lenses? NO YES Are you having problems wearing? YES NO
Are you interested in wearing contacts? YES NO

3. Are you currently taking any of the following medications?

Plaquenil (Hydroxychloroquine) Topamax (Topirimate) Gilenya (Fingolimod)

4. Have you ever been diagnosed with any of the following? (Please circle all that apply)

Glaucoma Cataracts Diabetes Family history of Glaucoma High Blood Pressure

5. Are you interested in any of the following? LASIK BOTOX JUVEDERM LATISSE

Below is an explanation of what routine and medical eye exams include and payment options at Dominion Eye:

A <u>ROUTINE</u> eye exam is to review the health of the eyes and your glasses or contact lens prescription if applicable. Only companies with very specific eye care plans pay for routine examinations. Refraction fees and contact lens fitting fees are in addition to the exam itself. Please be aware that you are responsible for advising us of your routine vision coverage prior to your eye exam. You may be able to use your routine benefits in our optical department. If you want this visit filed as routine, you must meet with a staff member to be sure that we participate with your insurance plan. If you have a ROUTINE DIAGNOSIS (no issues other than an updated prescription) and do <u>not</u> have a routine vision plan, we do ask that you pay for these services at the time of each visit. We accept cash, check, Visa, Discover and MasterCard. We will be happy to give you a receipt and a description of services rendered to enable you to file your insurance.
A <u>MEDICAL</u> exam is to assess any problems that you may be experiencing that may affect your vision (such as a change in your vision) or the comfort of your eyes (such as dry eyes or eye pain). If you are a patient who is being seen regularly in this office for a medical problem (e.g. glaucoma, cataracts, diabetes, etc.) or if you require specialized testing, your exam will be filed with your medical insurance. If your insurance requires a referral from your primary care provider you are responsible for obtaining the referral before you are seen.

Are you here today for a medical or a routine visit? (Please circle one) MEDICAL ROUTINE

If routine, what type of insurance do you have?____________________________________

If we participate with your insurance we must collect your co-payment at each visit. This is a requirement of our agreement with your insurance company. Your co-payment was designed by your insurance company to assist in covering the cost of providing care to you. If you do not pay your co-pay, you are violating your insurance contract. If we violate our participation agreement by not collecting your co-pay and are not allowed to participate with your insurance company, the cost of services to you will rise. If you have questions regarding your payment obligations or your particular insurance, trained staff members are available to help you with your insurance questions.
<u>It is important that you keep us up to date with changes in your insurance. If you are an established patient, you are responsible for letting us know if your insurance has changed since your last visit and providing us with your current insurance card so that we may make a copy for your records.</u> THANK YOU!

____

Patient/Parent or Legal Representative Signature **Date**

Dominion Eye Associates
and its affiliates and/or subsidiaries

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received a copy of Dominion Eye Associatesr Privacy Practices.

____
(Print Name)

____
(Signature)

____
(Date)

This acknowledgement page should be retained in the patient's record. If acknowledgement could not be obtained from patient, the reason(s) must be documented below.

____
____
____
____

RELEASE OF MEDICAL INFORMATION

By signing below, I authorize Dominion Eye Associates and affiliates and/or subsidiaries to disclose information regarding my eye care and treatment to the individuals listed below:

____
Name Phone Number Relationship

____
Name Phone Number Relationship

____
Name Phone Number Relationship

____
(Signature)

____
(Date)