Drs. DeVito & Martin

PATIENT REGISTRATION

Patient _____

Address _____

_____
City State Zip

Cell Ph: _____ Hm Ph: _____

Email: _____

Sex M F Birth date _____

Social Security Number _____

Employer _____

Employer Phone _____

Spouse's Name _____

Spouse's Phone: cell _____ wk _____ hm _____

How did you hear about our office? _____

EMERGENCY CONTACT

Name _____

Relationship _____

Phone number H _____ W _____

RESPONSIBLE PARTY INFORMATION

Name _____

Relationship _____

Address _____

City _____ State _____ Zip _____

Phone: cell _____ wk _____ hm _____

I establish the following people (other than myself) as my patient representatives and give my consent to Drs. DeVito & Martin to discuss / disclose my protected health information including but not limited to appointment times, prescriptions, and payment information.

_____ _____
Name Relationship

_____ _____
Name Relationship

I consent to receive calls and text messages from Drs. DeVito & Martin for my protected healthcare and other services at the phone numbers I listed above, including my cell phone. I understand I may be charged for calls by my wireless carrier and that such calls may be generated by an automated system.
I decline: text / automated messages (Please circle)

_____
Signature Printed Name Date

INSURANCE

Vision Insurance: _____

Subscriber Name: _____

DOB: _____ SSN# _____

ID# _____ Group _____

Primary Health Insurance: _____

Subscriber Name: _____

DOB: _____ SSN# _____

ID# _____ Group _____

Is Patient covered by additional insurance? Yes No

Secondary Health Insurance _____

Subscriber Name _____

ID# _____ Group _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage and assign directly to Drs. DeVito & Martin all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____
Responsible Party Signature Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to Drs. DeVito & Martin for services provided to me by Drs. DeVito & Martin. I authorize any holder of medical information about me to release to the Department of Medicare and Medicaid Services and its agents any information needed to determine those benefits payable for related Services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA 1500 form, or elsewhere on other approved claim forms or electronically submitted claim, my signature authorized releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and non covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____
Beneficiary Signature Date

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I acknowledge receipt of Drs. DeVito & Martin's Notice of Privacy Practices.

_____
Patient / Legal Authorized Signature Date

_____ _____
Printed Name Relationship to Patient

I understand that I am financially responsible for all charges, whether or not paid by insurance including all charges for services rendered which are denied, not prior authorized, or not covered by the applicable insurance company including copays and deductibles. All balances are due in full within 60 days, if you need more than 60 days to pay your balance, please make arrangements with our billing office. I understand that I am responsible for my account balance plus any reasonable collection and legal fees.

I understand that every pair of eyewear produced by Drs. DeVito & Martin is custom made to each patient's needs. For this reason, we can not accept returns except in rare circumstances. In the event that I may receive a refund, I may be charged a restocking fee of 30%. In the event that I choose to restyle to a different frame or lens design (including progressive lenses, multifocal, or single vision lenses), I need to pay for any extra cost. In the event that I choose a less expensive frame or lens design, fees may be retained by Drs. DeVito & Martin.

Patient / Legal Authorized Signature _____ Relationship to Patient _____ Date _____

MEDICAL HISTORY QUESTIONAIRE

Last Eye Exam: _____ **Do you wear glasses: Yes No** **Contact Lenses: Yes No**

Eye Surgery / Laser Treatment: _____ **Date:** _____

General Surgeries: _____ **Date:** _____

Medications: _____

Medication Allergies: _____

REVIEW OF SYSTEMS

Circle the symptoms / conditions you are CURRENTLY having. If none apply to you, please circle "None".

EYES
Blindness
Blurred Vision
Burning
Cataracts
Crossed Eyes
Distorted Vision (Halos)
Double Vision
Dryness
Excess Tearing/Watering
Eye Pain
Flashes/Floaters in Vision
Foreign Body Sensation
Glare/Light Sensitivity
Glaucoma
Infection of Eye or Lid
Itching
Keratoconus
Lazy Eye
Loss of Vision
Macular Degeneration
Mucous Discharge
Redness
Retinal Detachment
Retinal Disease
Sandy or Gritty Feeling
Styes or Chalazion
None

BONE / JOINT / MUSCLE
Arthritis
Joint / Muscle Pain
Fibromyalgia
Gout
Muscular Dystrophy
Osteoarthritis
None

CANCER
Breast
Lung
Prostate
Skin
Other: _____
None

CONSTITUTIONAL
Fever
Weight Gain / Loss (Sudden)
Developmental Disabilities
Fatigue
None

ENDOCRINE
Diabetes Type 1 - Type 2
AIC _____
Thyroid Disease
Hormonal Dysfunction
None

EAR, NOSE, AND THROAT
Allergies
Chronic Cough
Dry Mouth / Throat
Hay Fever
Hearing Loss
Laryngitis
Runny Nose
Sinus Congestion
None

GENITOURINARY
Kidney Disease
STD
None

INTEGUMENTARY (skin)
Eczema
Psoriasis
Rosacea
Shingles
Herpes Simplex Cold Sores
None

NEUROLOGIC
Cerebral Palsy
Epilepsy
Headaches
Migraines
Multiple Sclerosis
Seizures
Stroke
None

LYMPHATIC / HEM
Anemia
Hepatitis
Herpes
HIV +
Liver Disease
None

REPRODUCTIVE
Pregnant
Nursing
None

PSYCHIATRIC
Depression
High Anxiety
Bipolar Disorder
Attention Deficit
Schizophrenia
Other: _____
None

RESPIRATORY
Asthma
Chronic Bronchitis
Emphysema
Pneumonia
Tuberculosis
None

VASCULAR
Heart Disease
High Blood Pressure
High Cholesterol
Stroke
None

GASTROINTESTINAL (stomach)
Crohn's Disease
Colitis
Ulcers
Celiac Disease
None

IMMUNOLOGIC
Rheumatoid Arthritis
Lupus
Sjogren's Syndrome
None

FAMILY HISTORY

Please note any family member with the following disease / conditions: M-mother F- father S- sibling GP- grandparent

		YES	NO			YES	NO
Blindness	___	□	□	Diabetes	___	□	□
Cancer	___	□	□	Glaucoma	___	□	□
Cataracts	___	□	□	Heart Disease	___	□	□
Crossed Eyes	___	□	□	Hypertension	___	□	□
				Retinal Dz.	___	□	□

SOCIAL HISTORY

Health Habits
Check which substances you use and the consumption.

	YES	NO
Alcohol	□	□
Quantity: _____		
Drugs	□	□
Quantity: _____		
Tobacco	□	□
Quantity: _____		

Please list specific visual needs / problems related to work and hobbies.

_____

_____

_____

_____

Primary Care Physician: _____ **Address:** _____

Phone: _____ **FAX:** _____