INSURANCE REGISTRATION FORM

Patient Name: _____ DOB: _____

Patient Address: _____

Patient Phone: Home _____ Work _____

EMAIL: _____
Relationship to Insured: (Circle) Self - Spouse - Child - Other_____
Marital Status: (Circle) Single - Married - _____
Employment Status: (Circle) Full Time - Part Time - Student - Retired - _____

Primary Insurance:

[ ]Aetna [ ]Amerihealth [ ]Amerihealth Administrators
[ ]Blue Cross Blue Shield [ ]Horizon [ ]Keystone
[ ]Medicare [ ]Railroad Medicare
[ ] EyeMed [ ] VBA [ ] VSP
[ ]_____

Secondary Insurance:

[ ]AARP [ ]Aetna [ ]Amerihealth [ ]Amerihealth Administrators
[ ]Blue Cross Blue Shield [ ]Horizon [ ]Keystone
[ ]Medicare [ ]Railroad Medicare
[ ] EyeMed [ ] VBA [ ] VSP
[ ]_____

Insured Party Information - Check here if Self [ ]

Name_____Birth date_____

Social Security #_____

Address_____

Phone:_____Home _____Work _____Cell

Employer_____

Address_____

Spouse Name_____ Birth date_____

Social Security #_____

Address_____

Other members of the family:

_____Birth date_____ _____Birth date_____

Signature _____ **Name**_____ **Date**_____

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Address: _____

Primary reason for today's visit: (Circle) Routine Eye Examination - Other_____

_____

Health History	**Please list your medication.**
[ ] Allergies	_____
[ ] High blood pressure	_____
[ ] Heart disease	_____
[ ] Diabetes	_____
[ ] Thyroid	_____
[ ] Hormone	_____
[ ] Stomach-intestines	_____
[ ] Kidney-bladder)	_____
[ ] Blood	_____
[ ] Immune System	_____
[ ] Skin-Breast)	_____
[ ] Arthritis	_____
[ ] Neurological	_____
[ ] Psychiatric	_____
[ ] Asthma	_____
[ ] _____	_____

Do you have any medication allergies? List:_____

Eye History - Please check

[ ] Cataracts
[ ] Glaucoma
[ ] Macular Degeneration
[ ] Dry Eye
[ ] Lazy eye / Cross eye
[ ] Eye injury or other disease
[ ] Eye surgery
[ ] Using eye drops (List)_____

FAMILY HISTORY

OCULAR

[ ] Blindness
[ ] Cataract
[ ] Glaucoma
[ ] Macular degeneration
[ ] Retinal detachment

MEDICAL

[ ] Diabetes
[ ] High Blood Pressure
[ ] Other (list)_____

SOCIAL HISTORY	**If yes please circle**
Do you:	
[ ] Drink alcohol?	Social / 1-2 per day / Above average / Alcohol dependence
[ ] Use tobacco?	< 1 pack day / 1-2 pack day / > 2 packs day / Former ___yrs ago
[ ] Use narcotics?	Recreational use / Chemical Dependence

Signature: _____ Date: _____

Signature on File, Assignment of Benefits, Financial Agreement and Privacy Plan.

Name of Patient: _____Guarantor: _____

1) Medicare: I request that payment of authorized Medicare benefits be made to me or on my behalf to Joseph J. Reda, O.D., P.C. for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

2) Medigap: I request payment of authorized Medigap benefits be made to this provider and also authorize any holder of medical information about me to release to the Medigap insurer any information needed to determine benefits payable for services from this provider.

3) Other Insurance: I understand that Joseph J. Reda, O.D., P.C. maintains a list of insurance companies with which it contracts. Joseph J. Reda, O.D., P.C. agrees to accept assignment for covered services and products. Accordingly, the undersigned accepts full financial responsibility for all services and items which are determined not to be covered. If I belong to a plan that does not appear on the list the undersigned agrees to pay the full charges for all services and items rendered to me. I agree that in return for the services and items provided to the patient by Joseph J. Reda, O.D., P.C., I will pay my account at the time service is rendered for all co-payments, deductibles and non-covered fees. I authorize any holder of medical information about me to release to the insurance carrier and its agents any information needed to determine these benefits or the benefits payable for related services.

4) Referrals: I understand that if my insurance company requires referrals or pre-approvals I am responsible to obtain the necessary authorizations prior to the services being rendered. If I am unable to obtain the necessary authorization the undersigned agrees to pay the charges in full for all services and items.

5) Financial Agreement: It is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill. In the event a service or product is non-covered I agree to settle the account in full when services are rendered. A $5 per month late fee will be charged if my account is not paid in full within 30 days of service or failure of my insurance company to pay the balance. If my account is sent to a collection agency for collection, I agree to pay $35 for accounts settled in phase one (Correspondence) and an additional collection fee equal to 50% of the bill for accounts settled in phase two (Verbal). Retuned checks will be charged $30 and turned over to the collection agency if not paid within 7 days. All collection fees apply.

6) Privacy Plan: I agree that I have been given the opportunity to read and receive a copy of the Joseph J. Reda, O.D., P.C. notice of privacy practices.

This assignment will remain in effect until revoked by me in writing. A photocopy or digital copy of this assignment is to be considered as valid as the original.

_____
Name (print)

_____ _____ _____
Signature Relationship Date