REGISTRATION – *please print*

PATIENT INFORMATION

Last Name _____ First _____ Middle Initial _____

Birth Date _____/_____/_____ Age _____ Sex _____ Social Security # (Last 4 digits) - _____

Address _____ City _____ State _____ Zip _____

Cell Phone _____ Home Phone _____ Email _____

Occupation _____ Employer/School Name _____

Marital Status _____ Guardian Names (if applicable) _____

How did you hear about us? _____

INSURANCE INFORMATION

Medical Insurance _____ Group # _____ Member ID _____

Secondary Insurance _____ Group # _____ Member ID _____

Name of Primary Holder *(Last)* _____ *(First)* _____ *(MI)* _____

Birth Date _____/_____/_____ Sex _____ Social Security # _____ - _____ - _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Patient Relationship to the Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

SIGNATURE ON FILE

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits directly to **Montenare Eye Care & Vision Therapy, LLC** on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in Item 9 of the CMS-1500 claim form or electronically submitted claim), my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above. I understand that I am responsible for any amount of my bill not covered by insurance and/or Medicare and that payment for these uncovered charges are expected on day of visit.

Signature: _____ Date _____/_____/_____

Patient Signature or Legal Representative

HIPPA PRIVACY

In the course of providing services to you, we create, receive, maintain and transmit health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office. The "Notice of Privacy Practices" you have been given describes these uses and disclosures in detail. **I acknowledge that I have received the "Notice of Privacy Practices" from Montenare Eye Care & Vision Therapy, LLC.**

Signature: _____ Date _____/_____/_____

Patient Signature or Legal Representative

REGISTRATION – *please print*

Today's Date ____/____/____

Last Name _____ First _____ DOB ____/____/____ Sex _____

Primary Doctor _____ City/State _____

Race: ☐ Caucasian ☐ African-American ☐ Asian ☐ Other: _____
Ethnicity: ☐ Non-Hispanic ☐ Hispanic/Latino ☐ Other: _____
Primary Language: ☐ English ☐ Spanish ☐ Other: _____

MEDICAL HISTORY

Last eye exam? ____/____/____ Last physical? ____/____/____ Pregnant or nursing? *(For females)* □ No □ Yes

Please list any **eye conditions or surgeries** you have had *(include year)*: _____

_____

_____

Please list all **health conditions** you currently have or are being treated for: _____

_____

_____

Please list all **medications** you are taking *(include supplements, vitamins, or alternative medicines)*: _____

_____

_____

Please list any **allergies** to medications, dyes, anesthetics, or other: _____

_____

_____

List all **major injuries, surgeries, and/or hospitalizations** you have had *(include year)*: _____

_____

_____

FAMILY HISTORY

Do any of your blood relatives (members of your immediate family, living or deceased) have any of the following conditions?

DISEASE/CONDITION	NO	YES	RELATIONSHIP TO YOU
Cataracts	□	□	_____
Glaucoma	□	□	_____
Macular Degeneration	□	□	_____
Cancer	□	□	_____
High Blood Pressure	□	□	_____
Diabetes	□	□	_____
Cardiovascular Disease	□	□	_____
Other _____	□	□	_____
Other _____	□	□	_____

SOCIAL HISTORY □ *I would prefer to discuss my social history directly with the doctor (please check box)*

Do you drink alcohol? □ no □ yes Type/amount/how long: _____
Do you use tobacco? □ no □ yes Type/amount/how long: _____
Do you use illegal drugs? □ no □ yes Type/amount/how long: _____

VOCATION/HOBBIES

Any special vision requirements *(occupation/computer/hobbies)*? _____

(PLEASE CONTINUE)

REGISTRATION – *please print*

Do you currently have (or ever had) any problems in the following areas?

	NO	YES
GENERAL		
Fever	□	□
Unexplained weight changes	□	□
EYES		
Loss of vision	□	□
Blurred vision	□	□
Distorted vision/halos	□	□
Loss of side vision	□	□
Double vision	□	□
Dryness	□	□
Mucous discharge	□	□
Redness	□	□
Sand or gritty feeling	□	□
Itching or burning	□	□
Excess tearing/watering	□	□
Glare/light sensitivity	□	□
Eye pain or soreness	□	□
Chronic infection of eye or lid	□	□
Flashes or floaters in vision	□	□
Tired eyes	□	□
RESPIRATORY		
Asthma	□	□
Shortness of breath	□	□
GENITOURINARY		
Genitals/Kidney/Bladder	□	□
MUSCLES/BONES/JOINTS		
Rheumatoid Arthritis	□	□
Muscle or joint pain	□	□

	NO	YES
SKIN/BREAST		
Excessively oily skin	□	□
New rashes/moles	□	□
New lumps	□	□
NEUROLOGICAL		
Headaches	□	□
Nausea	□	□
Vomiting	□	□
Loss of motor control	□	□
PSYCHIATRIC	□	□
ENDORCRINE		
Thyroid	□	□
Other glands	□	□
BLOOD/LYMPHATIC		
Anemia	□	□
Bleeding problems	□	□
ALLERGY/IMMUNOLOGY		
Seasonal allergies	□	□
CARDIOVASCULAR		
Diabetes	□	□
High blood pressure	□	□
Vascular disease	□	□
GASTROINTESTINAL		
Diarrhea/Constipation	□	□
EAR/NOSE/THROAT		
Sinus congestion	□	□
Runny nose	□	□
Dry throat and mouth	□	□

Other: _____

_____

If you are here for a **VISION THERAPY EVALUATION**, please check all that apply:

- ☐ Headaches
- ☐ Eye strain/discomfort
- ☐ Tires easily
- ☐ Loses place while reading / use finger
- ☐ Skips words or lines when reading
- ☐ Rereads the same line frequently
- ☐ Poor reading comprehension
- ☐ Double vision
- ☐ Blurry vision
- ☐ Print "runs together"
- ☐ Words "jump" or "wiggle" on the page
- ☐ Eye turns in or out
- ☐ Avoids near tasks (reading, computer, etc.)
- ☐ Struggles with reading/learning
- ☐ Confuse left & right
- ☐ Reverse letters, numbers, or words
- ☐ Difficulty discriminating shapes or colors
- ☐ Difficulty finding similarities/differences in things
- ☐ Easily get lost or confused with information
- ☐ Easily frustrated with "visually demanding" tasks
- ☐ Trouble learning letters, numbers, words, or shapes
- ☐ Poor memory (especially with visuals and pictures)
- ☐ Poor spelling
- ☐ Slow at processing new visual information
- ☐ Difficulty "visualizing" a picture
- ☐ Poor eye-hand coordination
- ☐ Poor handwriting or fine motor control with pencil/pen
- ☐ Other: _____

REGISTRATION – *please print*

PUPIL DILATION

Pupil dilation is recommended for all of our patients as part of their yearly eye exam. The procedure uses eye drops to enlarge the pupils, allowing the doctor to view the peripheral retina to properly assess eye health and screen for potentially vision-threatening conditions. The dilated exam aids in the detection and assessment of **cataracts, glaucoma, macular degeneration, retinal tears or detachments, tumors,** and other conditions affecting the eye**.**

A dilated exam may also reveal early signs of **diabetes, vascular disease, and hypertension.** Patients with a personal or family history of diabetes, high blood pressure, any known eye disease, and those having high prescriptions are strongly advised to have their eyes dilated yearly.

Important: The short-term side effects of the dilating drops include sensitivity to light, blurred vision at near, and possibly blurred vision at distance. Driving is usually not impaired. However, if you feel uncomfortable operating a vehicle under these conditions, you should reschedule dilation for another day. The effects of the drops usually last 4-6 hours. As with all medications, rare but serious side effects can occur.

- ☐ **I DO** want pupil dilation today and understand my vision may be impaired.
- ☐ **I WANT TO RESCHEDULE** for pupil dilation.
- ☐ **I DO NOT** want pupil dilation. In refusing this test, I release Montenare Eye Care & Vision Therapy, LLC and its doctors and staff of any liabilities that result from not having this test performed.

I have been informed by Montenare Eye Care & Vision Therapy, LLC of the need for pupil dilation. It has been explained to me and I understand that, without these tests, existing eye diseases and conditions may go undetected.

Patient Name _____

Signature _____ Date _____/_____/_____

Patient Signature or Legal Representative