Insurance Waiver Form

Date: __________

Patient Name: _________________________ Date of Birth: _______________

Insurance Name: ________________________

Your visit for today will be billed through your medical insurance.

- ○ The visit today will be charged to your insurance carrier. You have had previous Lasik surgery and the evaluation is no longer free. Charges today will be billed to your insurance carrier. You will be responsible for your copay, deductibles and coinsurance.
- ○ During your visit today, which was originally scheduled for a free Lasik Evaluation, we have identified a medical problem which should be evaluated. The office visit and testing will be billed to your insurance carrier, you are still responsible for your copay, deductibles and coinsurance.
- ○ The visit today will be charged to your insurance carrier, this is not a free evaluation. Yaldo Eye Center feels that it is important that we monitor your medical condition. Charges today will be billed to your insurance carrier. You will be responsible for your copay, deductibles and coinsurance.
- ○ The visit today will be charged to your insurance carrier. You have had previous surgery with us but you are out of your post-op period. You will be responsible for your copay, deductibles and coinsurance.

By signing below, I am confirming that I have been properly notified that today's visit will be billed to my medical and/or vision insurance. I understand that my insurance carrier may or may not cover all of the testing/visit done today, this may result in a patient balance. Therefore, I agree to accept full responsibility for payment for today's visit. I understand that it is my responsibility to notify Yaldo Eye Center of any changes in my insurance.

_________________________ Patient signature

____________ Date

Patient Registration Form

Patient Name			Cell Phone*		Alternate Phone*
E-mail			Occupation or Previous Occupation		
Address			City	State	Zip Code
Gender ☐ Male ☐ Female	Marital Status ☐ Single ☐ Married ☐ Widowed	Social Security Number			Date of Birth

Insurance Information

Primary Medical Insurance

Subscriber Name: ______________________________ Group Number: ______________

Policy Number: ________________________________ Subscriber DOB : ______________

Secondary Medical Insurance (if any)

Subscriber Name: ______________________________ Subscriber DOB ______________

Policy Number: ________________________________ Group Number: ______________

Vision Insurance (if any)

Subscriber Name: ___________________ Policy Number: ______________________

Emergency Contact Information:

Name: _______________________________________ Phone: ______________________________

How did you hear about us? ____

Authorization: I hereby authorize the release of any medical information necessary to process my insurance. I also hereby authorize payment directly to the provider of services. I understand that I am financially responsible for charges not covered by this authorization.

Acknowledgement: I acknowledge that interest may be charged on all accounts that are 90 days or more past due at a rate of 1½% per month, annual rate 18%. I understand that interest charges will be added to any account I have that is 90 days or more past due and hereby agree to pay such charges if levied.

* I agree that Yaldo Eye Center is authorized to reach me at any phone number provided and may leave a message if I am not available. I may also be contacted by e-mail.

Please initial here to acknowledge you have received our Office's Notice of Privacy Form (HIPPA Form) ________ **(initial)** ________ **(witness)**

Medical Health History Form

Have you had any injury to your eyes? ________________ ☐ Yes ☐ No
Have you had a lazy eye? ☐ Yes ☐ No
Have you had a detached retina? ☐ Yes ☐ No
Have you had any prior eye surgeries? ☐ Yes ☐ No
If yes, what kind? ______________________________
Has a family member had glaucoma? ☐ Yes ☐ No
If yes, who? __________________________________
Has a family member had a detached retina? ☐ Yes ☐ No
If yes, who? __________________________________
Have you had any prior surgeries? (Not eye related) ____

PAST MEDICAL HISTORY

Do you now or have you ever had:

☐	Diabetes	☐	HEART PROBLEMS	☐	Crohn's disease
☐	High Blood Pressure	☐	HEART ATTACK	☐	Ulcerative Colitis
☐	High Cholesterol	☐	HEART MURMUR	☐	Stroke
☐	Thyroid Issues	☐	PULMONARY EMBOLISM	☐	Epilepsy (seizures)
☐	Ulcers	☐	BREATHING PROBLEMS	☐	Kidney Disease
☐	Cancer (type) ___________	☐	COPD	☐	Kidney Stones
☐	Weight Loss	☐	EMPHYSEMA	☐	Hepatitis
☐	Psoriasis	☐	ASTHMA	☐	Tuberculosis
☐	Headaches	☐	PROSTATE ISSUES	☐	Cortisone Shots/Cream
☐	Sinus Problems	☐	Eczema	☐	HIV/AIDS
☐	Bleeding Problems	☐	Arthritis	☐	Joint Pain
☐	Depression	☐	Liver Problems	☐	Nervous Problems

Other Medical Conditions: (Please List): ____
____

List all medications you are taking: ____
____

Are you allergic to any medication? ☐ Yes ☐ No
If yes, what kind? ______________
Do you smoke? If yes, how many pack per day? ________ ☐ Yes ☐ No
Do you drink alcohol? If yes, how often? _____________ ☐ Yes ☐ No

Primary Care Doctor (Family Doctor)

Name: ___________________________
City: ____________________________
Phone Number: ___________________

Pharmacy Information

Name: _________________________
Address/Location: ________________________
Phone Number: ________________________

Patient Signature: _________________________________ **Date:** ______________

Patient Name: _____________________________________