McMANN EYE INSTITUTE

Patient Registration

Last Name:_____ Sex: Male / Female

First Name:_____ Date of Birth: _____

Middle Name / Initial: _____ Age: _____

Soc. Sec. #: _____

Address:_____ Marital Status: Single / Married /Divorced

City:_____State:_____Zip:_____ Widowed / Other

Home Tel: # _____ / Cell Tel: #: _____ / Work Tel: #: _____

Texting OK? Yes / No

Email Address: _____Fax # _____

Employment Status: Full Time / Part Time / Homemaker/ Student / Active Duty Mil. / Retired

Employer: _____ / Occupation:_____

How did you hear about us or who referred you? _____

Who is your Primary Care Doctor? _____

Insurance Information:

Insurance Type: 1._____ 2._____3._____

Policy #:_____

Subscriber Name: (Last):_____ (First):_____

Subscriber Date of Birth:_____ / Soc. Sec. # _____

Are you interested in learning more about Laser Vision Correction? Yes / No

List any medications you currently take (prescription and over-the-counter):_____

_____

Do you have new allergies to any medications, since your last visit? YES NO

If YES, list the medications:_____

List all major illnesses (glaucoma, diabetes, high blood pressure, heart attack, etc.) or injuries (concussion, etc.)

_____

List any surgeries you have had (cataract, tonsillectomy, appendectomy, etc.):_____

_____

DO YOU **CURRENTLY** HAVE ANY PROBLEMS IN THE FOLLOWING AREAS?

If **YES**, please provide information.	**YES**	**NO**	**Details**	**Since when?**
EYES				
Loss of vision				
Blurred vision				
Fluctuating vision				
Distorted vision (halos)				
Glare or light sensitivity				
Loss of side vision				
Double vision				
Dryness				
Mucous discharge				
Redness				
Sandy or gritty feeling				
Itching				
Burning				
Foreign body sensation				
Excess tearing or watering				
Eye pain or soreness				
Infection of eye or lid				
Tired eyes				
Crossed eyes, lazy eye				
Drooping eyelid				
ALLERGIC/IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, etc.)				
CARDIOVASCULAR (high BP, racing pulse, etc.)				
GENERAL/CONSTITUTIONAL (fever, weight loss, other)				
ENDOCRINE (diabetes, hypothyroid, etc.)				
GASTROINTESTINAL (stomach upset, diarrhea, constipation, etc.)				
GENITAL, KIDNEY, BLADDER (painful urination, frequent urination, impotence, etc.)				
BLOOD/LYMPH (cholesterolemia, anemia, etc.)				

DO YOU **CURRENTLY** HAVE ANY PROBLEMS IN THE FOLLOWING AREAS?	**YES**	**NO**	**Details**	**Since when?**
IMMUNOLOGIC (mumps, chickenpox, measles, etc.)				
SKIN (pimples, warts, growths, rash, etc.)				
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, etc.)				
NEUROLOGICAL (numbness, headache, etc.)				
PSYCHIATRIC (anxiety, depression, insomnia, etc.)				
RESPIRATORY (asthma, COPD, bronchitis)				

FAMILY HISTORY	**M**= mother **F**=father **S**=siblings **GP**=grandparent		
DISEASE	**YES**	**NO**	**RELATIONSHIP TO PATIENT**
Blindness			
Glaucoma			
Arthritis			
Cancer			
Diabetes			
Heart disease or high blood pressure			
Kidney disease			
Lupus			
Stroke			
Thyroid disease			
Other			

SOCIAL HISTORY

Do have difficulty when driving? **YES** **NO**

Do you have problems with night vision? **YES** **NO**

Have you ever tried to wear contact lenses? **YES** **NO**

Do you currently wear glasses? **YES** **NO**

(If yes, how long have you had your current prescription?): _____

Do you drink alcohol? **YES** **NO**

If YES: occasional 1/day 2-3/day 4+/day

Do you smoke? **YES** **NO**

If YES: ½ pack/day 1pack/day 1+pack/day

Our Financial Policy

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policy.

1. Payment is due at the time of service unless arrangements have been made in advance by your insurance carrier. We accept Cash, Personal Check, American Express, Discover, Visa and MasterCard.

2. Keep in mind that your insurance policy is basically a contract between you and your insurance company. As a service to you, we will file your insurance claim if you assign the benefits to the doctor—in other words, if you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable time period, we will have to look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you.

3. We have made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits. We will gladly bill them, however you are required to pay a co-payment at the time of your visit.

4. If you are insured by a plan that we do not have a prior arrangement with, we will prepare and send the claim for you on an unassigned basis. This means the insurer will send the payment directly to you. Therefore, our charges for your care are due at the time of service.

5. Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

6. We will bill your insurance company for all services provided in the hospital. You are responsible for any balance due. I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

(A) FINANCIAL RESPONSIBILITY AGREEMENT:
I hereby authorize my insurance company to pay the proceeds of any benefits directly to Dr. Michael A. McMann, MD., LLC. / McMann Eye Institute. A copy of this can be used as an original for insurance purposes.

I agree to pay my co-payment portion as services are provided. If there is any remaining balance owing, I agree to pay promptly upon receipt of a statement. I am aware of the additional charge for returned checks of $25.00.

(B) ACKNOWLEDGEMENT OF PRIVACY NOTICE:
I have been provided an opportunity to read and review the NOTICE OF PRIVACY PRACTICES; or to receive a copy per my request ($0.50) as required by HIPPA regulations.

_____ _____

Patient's Signature / Legal Guardian Signature Date