

Clarity Eye Center PLLC Registration Form

PATIENT INFORMATION

Patient Name: _____ Date of Birth: ____/____/____

First Name
Middle Initial
Last Name

Mailing Address: _____

Street Address (If Different): _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work/Alternate Phone: _____

Social Security #: _____ Driver's License #: _____

Employer: _____ Address: _____

Male Female Single Married Separated Divorced Widowed

SPOUSE INFORMATION

Spouse Name: _____ Date of Birth: ____/____/____

First Name
Middle Initial
Last Name

Address (If different): _____

Home Phone: _____ Work Phone: _____ SS # _____

Relative or Friend not living with you for messages in case we are unable to reach you:

Name: _____ Relationship: _____ Phone: _____

Primary Insurance Company

Name:	Policy ID Number:	Group Number:
Street Address:	City	State/Zip Code
Name of Policy Holder:	SS #:	Relationship to Insured:

Secondary Insurance Company

Name:	Policy ID Number:	Group Number:
Street Address:	City	State/Zip Code
Name of Policy Holder:	SS #:	Relationship to Insured:

**** We Will Copy Your Insurance Cards At The Time Of Your Visit ****



Privacy and Payment Agreement

Privacy Agreement:

With my consent, Clarity Eye Center may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). I authorize the release of any information by phone, fax, or mail including diagnosis and records of any treatment rendered to me to this referring Physician, or other healthcare practitioners in my care, my Insurance Company, or its agents. I understand that refusal to authorize disclosure of all or some of the health care information may result in improper diagnosis or treatment, denial of insurance coverage, and other adverse consequences.

Clarity Eye Center reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Clarity Eye Center Privacy Officer at 301 Seton Parkway, Suite 100, Round Rock, Texas 78665.

By signing this form, I am consenting to Clarity Eye Center's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Clarity Eye Center may decline to provide treatment to me.

Payment Agreement:

Refraction is a test used to determine eye glasses prescription. Many insurance companies do NOT cover the cost of refraction, currently set at \$35, and patients will be billed this amount upon denial from their insurance company. MEDICARE does NOT ever pay for refractions. Patients with MEDICARE will be required to pay this fee at the time of service. **I understand that I am financially responsible for all services rendered to me.**

Unless prior mutually agreed upon financial arrangements have been made by Clarity Eye Center and me, **I will pay in full for all services rendered to me.**

I request that payment of authorized insurance benefits be made on my behalf to Clarity Eye Center for any services rendered by Clarity Eye Center.

Signature of Patient or Responsible Party

Date

*** This signature remains valid for a period not to exceed 30 months ***

Medicare Patients

I request that payment of authorized Medicare benefits be made to me or on my behalf to Clarity Eye Center for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents needed to determine these benefits payable for related services.

Signature of Patient or Responsible Party

Date

*** This signature remains valid for a period not to exceed 12 months ***



Clarity Eye Center, PLLC
301 Seton Parkway, Suite 100
Round Rock, TX 78665
PH: (512) 244-7200
FX: (512) 244-7207

MEDICAL HISTORY FORM

DATE: _____

Patient name _____ Age _____ Date of Birth _____
 Previous Eye Doctor _____ Address _____
 Primary Physician _____ Address _____
 Specialists (currently seeing) _____ Address _____

Have you had serious eye problems or eye surgery in your past? Yes No
 If yes, please explain. (Use opposite side of page if necessary)

List other previous serious illness with approximate dates _____

Please list all medications you currently take (Or, please give us a copy of medication list) _____

Are you allergic to any medications? Yes No Please list _____

Have you had or has a family member had:

- | | | | |
|------------------------|--|---|--|
| ❖ Glaucoma | <input type="checkbox"/> you <input type="checkbox"/> family | ❖ Cancer | <input type="checkbox"/> you <input type="checkbox"/> family |
| ❖ Macular degeneration | <input type="checkbox"/> you <input type="checkbox"/> family | ❖ High cholesterol | <input type="checkbox"/> you <input type="checkbox"/> family |
| ❖ Cataracts | <input type="checkbox"/> you <input type="checkbox"/> family | ❖ Diabetes | <input type="checkbox"/> you <input type="checkbox"/> family |
| ❖ Retinal detachment | <input type="checkbox"/> you <input type="checkbox"/> family | | |
| ❖ Amblyopia (lazy eye) | <input type="checkbox"/> you <input type="checkbox"/> family | Social History | |
| ❖ Vascular disease | <input type="checkbox"/> you <input type="checkbox"/> family | Smoking history (packs per day) _____ | |
| ❖ Stroke | <input type="checkbox"/> you <input type="checkbox"/> family | Alcohol consumed per week _____ | |
| ❖ Heart disease | <input type="checkbox"/> you <input type="checkbox"/> family | Women: Are you pregnant? ____ Yes ____ No | |
| ❖ Hypertension | <input type="checkbox"/> you <input type="checkbox"/> family | | |

Please mark those that apply to you:

- | | | |
|---|--|--|
| <input type="checkbox"/> Weight gain or loss | <input type="checkbox"/> Skin disorders | Any other medical problems not listed? (If yes, please list)

_____ |
| <input type="checkbox"/> Unexplained fatigue | <input type="checkbox"/> Autoimmune disorder | |
| <input type="checkbox"/> Unexplained fever | <input type="checkbox"/> Infectious disease | |
| <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Arthritis | |
| <input type="checkbox"/> Nose or throat problems | <input type="checkbox"/> Muscular dystrophy | |
| <input type="checkbox"/> Hard of hearing | <input type="checkbox"/> Injury to extremity | |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Stroke | |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Parkinson's disease | |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Tremors | |
| <input type="checkbox"/> Chest pain (angina) | <input type="checkbox"/> Migraine or other severe headache | |
| <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Multiple sclerosis | |
| <input type="checkbox"/> Elevated cholesterol | <input type="checkbox"/> Anemia or swollen glands | |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Eczema, hives | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hay fever | |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Anxiety | |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Depression | |
| <input type="checkbox"/> Frequent cough | <input type="checkbox"/> Psychiatric illness (please list) _____ | |
| <input type="checkbox"/> Ulcer | <input type="checkbox"/> Diabetes | |
| <input type="checkbox"/> Frequent heartburn | <input type="checkbox"/> Thyroid disease | |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> HIV / AIDS | |
| <input type="checkbox"/> Colitis / diverticulitis | <input type="checkbox"/> Cancer | |
| <input type="checkbox"/> Kidney disease (on dialysis) | | |
| <input type="checkbox"/> Enlarged prostate | | |

CONTACT LENSES

If currently wearing contact lenses, please indicate the following:
 Type of CL: ____ Hard ____ Soft
 ____ Daily Wear ____ Extended
 Wear (CL's you sleep in) _____
 Manufacturer _____
 Lens Name _____
 Power: _____
 Right _____ Left _____
 Base Curve _____ Diameter _____
 Solution currently using: _____