NEW PATIENT REGISTRATION

In order to provide you the best possible care, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL.

Contact Information

First Name _____
Last Name _____
Daytime Phone _____
Mobile Phone _____
Email _____

Street Address _____
Suite/Apt. _____
City _____
State _____
Zip Code _____

Guardian Information *(if patient is under 18 years of age)*

First Name _____
Last Name _____
Daytime Phone _____
Mobile Phone _____
Email _____

Street Address _____
Suite/Apt. _____
City _____
State _____
Zip Code _____

Patient Information

Gender _____
Date of Birth _____
Social Security No. _____

Primary Insurance Information

Provider Name _____
Provider Phone _____
Policy/I.D. No. _____
Group No. _____

Secondary Insurance Information

Provider Name _____
Provider Phone _____
Policy/I.D. No. _____
Group No. _____

Additional Insurance Information

Provider Name _____
Provider Phone _____
Policy/I.D. No. _____
Group No. _____

Office Policies: Patients that arrive late but within 20 minutes of the scheduled appointment may be worked into the schedule but may have a wait. Patients late beyond 20 minutes will have to reschedule.

All Contacts, Glasses and Low Vision Aids require a 50% down payment before the order can be placed. Custom lenses must be paid in full before they can be ordered.

REGARDING INSURANCE

If you have insurance, we will help you receive your benefits. An insurance claim will be completed if we are furnished with full insurance information. Otherwise, you are responsible for payment at the time of service. Claims not paid within 60 days, for any reason will be transferred to the patient for payment.

INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. We will inform you if we are a party to your insurance contract, and will handle your claim according to our agreement with the company. We file insurance claims as a courtesy to our patients. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered services, secondary insurance, "usual and customary" charges, etc., other than to supply factual information as necessary.

BILLING POLICY

To avoid billing fees, please settle your account of the day of service. There is a 5% charge for all non-insurance billing services. Past due bills beyond 30 days carry a 2% interest charge per month not to exceed the maximum annual interest charge as dictated by Pennsylvania Law.
Returns: All material purchases are only subject to a return at the ordering doctor's discretion. Used, opened, or damaged materials will not be refunded. All materials have up to a 50% restocking fee

HOW WILE YOU SETTLE YOUR ACCOUNT TODAY?
◯ CHECK ◯ CASH ◯ CREDIT CARD

THANK YOU FOR UNDERSTANDING OUR INSURANCE AND BILLING POLICY.
I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT THE SECTIONS THAT I HAVE COMPLETED ARE TRUE AND ACURATE.

Signature agreeing to all above terms _____ Date _____

Edmonds & Associates, LLC
dba Edmonds eye Associates, Great Valley Eye Associates

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

I authorize the professional office of my optometrist named above to release health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms and conditions:

The office often participates in research or marketing programs to advance the treatment or management of ocular or visual problems. To make these programs effective, we may need to identify you as having certain eye problems or conditions to make you eligible to participate in these programs. Once identified an informed you will have the opportunity to review the specific information and make a decision on your participation.

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

[For marketing authorizations, include, as applicable: We will receive direct or indirect remuneration from a third party for disclosing your identifiable health information in accordance with this authorization.]

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Date _____Signature _____

(Signature above means I AGREE to the policy.)

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient _____ Print Name_____

Source of Authority_____

_____

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of the office Notice of Privacy Practices.

Patient name _____

Signature _____ Date _____

(Signature above means I DO NOT AGREE to the policy, but I am aware of it.)

PATIENT HISTORY

Vision Correction History *(please check any that apply)*

- Amblyopia (lazy eye) ☐
- Blurred vision at a distance ☐
- Blurred vision at near ☐
- Burning ☐
- Double vision ☐
- Drooping eyelid(s) ☐
- Dryness ☐
- Eye pain and/or soreness ☐
- Floaters or spots ☐
- Fluctuating vision ☐
- Foreign body sensation ☐
- Halos ☐
- I experience regular headaches ☐
- I stopped wearing contact lenses ☐
- I stopped wearing glasses ☐
- Infection of eye or lid ☐
- Itching ☐
- Loss of peripheral vision ☐
- Loss of vision ☐
- Mucous discharge ☐
- Redness ☐
- Sandy or gritty feeling ☐
- Sensitivity to light/glare ☐
- Strabismus (crossed eye) ☐
- Tired eyes ☐
- Watery eyes ☐

Glasses History *(check all that apply)*

What glasses do you own?

- Backup pair ☐
- Bifocals ☐
- Distance ☐
- Progressive lens ☐
- Reading ☐
- Other: ☐
- Safety glasses ☐
- Single vision ☐
- Sports glasses ☐
- Sunglasses ☐
- Trifocals ☐

How many hours per day do you spend using a computer? _____

Check any that apply

- Allergic to nickel (frames) ☐
- I do not want to wear glasses ☐
- Incorrect prescription ☐
- Need spare glasses ☐
- Need sunglasses with UV ☐
- Problems with current glasses ☐
- Problems with glare ☐
- Problems with night vision ☐

Contact Lens History *(check all that apply)*

- What brand of contacts do you wear? _____
- How old are your current contacts? _____
- How often do you replace them? _____
- What solution do you use for soaking? _____
- What is your typical wearing schedule? _____

Check any that apply

- I do not want to wear contacts ☐
- Incorrect prescription ☐
- Interested in non-surgical correction ☐
- Interested in refractive laser surgery ☐
- Need spare contacts ☐
- Problems with current contacts ☐
- Would like to change my eye color ☐

Family History *(check all that apply)*

- Blindness ☐
- Diabetes ☐
- Eye turn/lazy eye ☐
- Glaucoma ☐
- Hypertension ☐
- Macular degeneration ☐

Allergies *(please list)*

- None ☐

PATIENT HISTORY

General Medical History *(please answer appropriately)*

When (approx.) was your last eye exam? _____

Primary care physician name _____

Primary care physician phone _____

Please list all eye conditions you have experienced:

Surgeries:

Do you have any of the following?

- Arthritis ☐
- Asthma ☐
- Cancer ☐
- Diabetes ☐
- Heart disease ☐
- High cholesterol ☐
- HIV ☐
- Hypertension (high blood pressure) ☐
- Migraines/headaches ☐
- Multiple sclerosis (MS) ☐

Other:

Referral Information

Why did you visit us?

- Referred by your doctor ☐
- Visited our website ☐
- Found us on social media ☐
- Referred directly ☐

Keep in touch

Facebook email _____

@Twitter handle _____

Questions and notes

Do you have a question? Concern? We want to know.