WIGGINS EYE CENTER

REGISTRATION FORM

PATIENT INFORMATION

Last Name _____ First Name _____ M.I. _____
Nickname _____

Marital Status: Single_____ Married_____ Divorced_____
Widowed_____ Legally Separated _____

Patient D.L.# _____ State _____

Social Security# _____ Date of Birth _____

Sex: Male / Female (circle one)

Preferred Language: English_____ Spanish_____ Other_____

Ethnicity: Hispanic/Latino_____ Not Hispanic/Latino_____

Race: Asian_____ White_____ American Indian or Alaska Native_____ Black or African American_____ Other_____

Emergency Contact: (relative, neighbor, or friend) _____

Phone# _____

Spouse Full Name:_____

Phone# _____

Caretaker Full Name:_____

Phone# _____

Patient Home Phone# _____ Work Phone#_____
Cell Phone# _____

Preferred Contact By: Home#_____ Work#_____ Cell#_____

Is it okay to leave a detailed message? Yes_____ No_____

Email Address_____

Mailing Address _____

City _____ State _____ Zip _____

Employer Name _____

Not Employed_____ Retired _____

Medical History

(Do you currently or have you had any of the following? (Please Check All That Applies)

Heart Disease____ COPD____ Asthma, Emphysema_____ Arthritis_____

Diabetes_____ Thyroid Disease_____ Kidney Stones/ Kidney Disease_____

Strokes_____ High Cholesterol_____ HIV_____ Hepatitis_____ A, B, or C

Cancer _____ High Blood Pressure _____ Glaucoma_____ Macular Degeneration_____

Retinal Detachment_____ Currently Pregnant _____ Due Date_____

CATARACT SURGERY: Yes or No Dates _____

Other Past Surgical History: _____

MEDICATION ALLERGIES: _____

CURRENT MEDICATIONS: _____

Attach List or can continue on the back with medication list

Vaccines (check the one that applies)

Flu_____ Shingles_____ Pneumonia _____ Covid 19_____

Family Medical History (circle one that applies)

Cataracts:	Father	Mother	Grandparents
Heart Disease	Father	Mother	Grandparents
Glaucoma	Father	Mother	Grandparents
Macular Degeneration	Father	Mother	Grandparents
Diabetes	Father	Mother	Grandparents
High Blood Pressure	Father	Mother	Grandparents

Social History (circle one that applies)

Drug Usage	Daily	Social	Never	Former
Alcohol Usage	Daily	Social	Never	Former
Tobacco Usage	Daily	Social	Never	Former
Living Arrangements	Alone	Spouse	Family	Nursing

PERSON RESPONSIBLE FOR THE BILL (ONLY APPLICABLE IF OTHER THAN THE PATIENT)

Last Name _____ First Name _____ M.I. _____
Relationship to Patient _____

Social Security# _____

Date of Birth_____

Mailing Address _____ City
_____ State _____ Zip _____

Home Phone#_____ Work Phone#_____

Cell Phone# _____

INSURANCE INFORMATION (PLEASE LIST POLICY HOLDER IF OTHER THAN THE PATIENT)

Name _____
Date of Birth_____

ADDITIONAL INFORMATION

Local Pharmacy _____

Address_____

Mail-In Pharmacy _____
Address_____

Referring Physician _____

Primary Care Physician_____

PLEASE READ AND SIGN BELOW

I authorize the physicians and staff of Wiggins Eye Center to perform procedures necessary to access and diagnose my condition properly and to perform treatments as may be prescribed by my attending physicians during all visits to Wiggins Eye Center. I understand that I am financially responsible for ALL charges for services rendered to me by Wiggins Eye Center.

Signature_____

Date_____

If you provided your insurance cards at check in, please disregard.

Primary Insurance Company:_____

Member ID Number:_____

Group Number:_____

Name of person carrying this insurance:_____

Date of Birth_____ Social Security Number_____

Secondary Insurance Company:_____

Member ID Number:_____

Group Number:_____

Name of person carrying this insurance:_____

Date of Birth_____ Social Security Number_____

Assignment of Benefits/Authorization to release information

I hereby authorize Wiggins Eye Center to release any information concerning my care for the purpose of claims to federal, state, or town governmental agencies, third party payers of all categories, doctors and hospitals.

I hereby authorize payment directly to Wiggins Eye Center from insurance benefits, including Medicare, herein specified and otherwise payable to me, but not to exceed the regular charges for this period of admission. I understand that I am financially responsible to Wiggins Eye Center for charges not covered by this authorization.

I permit a copy of this authorization to be used in place of the original.

Signature of Patient:_____
Date_____

Signature of responsible Person: _____
Date_____

I acknowledge that I have received a copy of the: "Wiggins Eye Center's Notice of Privacy Practices"

(You may ask for a copy of Privacy Practices at the front desk if you want one)

Print Patient Name:_____

Patient Signature:_____

Patient Financial Responsibility

Recognizing the need for patients to understand what is expected regarding payment of medical services, we have established our financial policy. Some of these items are required by law. It is our goal to remain sensitive to our patients needs while providing quality medical care, and we encourage you to contact our office if a problem should arise regarding your account.

1. ***All co-pays required by your insurance company must be paid at the time services are rendered.*** We accept cash, checks, Visa, Mastercard, Discover and American Express cards. There is *a* ***$40.00*** service charge on all returned checks. After receiving a returned check, Wiggins Eye Center will only accept cash, money order, or debit/credit cards.
2. ***It is the patient's responsibility to be an aware of the contract benefits of his/her insurance carrier or any copayment or deductible obligation.*** If your insurance requires referrals for full benefits to be paid, it is your responsibility to verify that the referrals are in place prior to your visit. If we are not in network, you will be billed out of network charges.
3. ***Our facility will file both primary and secondary insurance claims for medical services rendered***. Claims for a third insurance contract will not be filed unless required by our contract with the carrier. We cannot file claims correctly without accurate information from you. Proof of insurance must be presented at each visit.
4. ***If you do not have insurance,*** payment in full is expected at the time of service unless financial arrangements have been made in advance with our office. As an alternative, we accept Care Credit and can assist with the application process.
5. ***We are participating providers for Medicare***. Medicare will pay 80% of the approved amount. The patient is responsible for the remaining 20%, plus any out-of-pocket deductible. If you have secondary insurance, we will submit the claim for the remaining balance after Medicare has paid. Please remember that although we accept assignment for Medicare, the patient, by federal law, is responsible to any portion of the approved amount not paid by Medicare or a secondary insurance company.
6. ***Responsibility for payment for services rendered to the child/children of divorced or separated parents'*** rests with the parent who seeks treatment. Any court ordered judgement must be between the individuals involved, without including our facility.
7. ***In the unlikely event your payment is returned to us unpaid***, we may elect to re-present your payment, either electronically or by paper draft, to your financial institution up to two more times. We may also collect a return processing charge by the same means, is an amount not to exceed that permitted by state law.

Patient's Signature or Authorized Representative or Guardian	Patient Date of Birth	Date