PATIENT REGISTRATION FORM

Today's Date: _____

Mr. Mrs. Miss Ms. _____ **Date of Birth:** ___/___/___
Last First Initial

Address: _____ City: _____ State: _____ Zip: _____

Home Ph# ( )_____**Work Ph# ( )**_____**Cell Ph# ( )**_____

Social Security No. _____ - _____ - _____ **Marital Status:** S M D Widow Legal Separated

Employer: _____ or **RETIRED** **Sex:** M or F

Address: _____ City: _____ State _____ Zip: _____

Emergency Contact Name: _____ **Relationship:** _____ **Phone#** _____

Family Doctor: _____

Other physicians following your care: _____

_____

EMAIL Address: _____@_____ **How did you hear about us?** _____
(Ex: family, friends,TV, billboard, web.internet, phone booth.)

PRIMARY INSURANCE:

Name: _____ Subscriber Name: _____SS# _____ DOB_____

SECONDARY INSURANCE:

Name: _____ Subscriber Name: _____SS# _____ DOB_____

RESPONIBLE FOR PAYMENT:

GUARANTOR (If under 18 yrs. old) **POA** (If in Nursing Facility)

Name: _____ DOB: _____ Social Security No. _____

Address: _____ City: _____ State: _____ Zip: _____

Fava & Maria
Eye Associates
875 Norman Drive · Lebanon · PA · 17042
(717) 272 - 2010

Name: **Date:**

DOB: **Age:** **Family Doctor:**

Preferred Language:_____

Race: (please circle): American Indian Asian African American White Hispanic/Latino Other

Past Eye History:

Date of last eye exam?_____ Name of Eye Doctor:_____

Do you wear/have you ever worn contacts? □Yes □No □ In the past □Worn overnight

Brand of contacts: _____

Have you ever been treated for a "lazy" or crossed eye? □ Yes □ No When?_____

□ Worn glasses? □Had LASIK or refractive surgery? When?_____

Do you have:
□ Glaucoma □ Cataracts □ Eye Injury

□ Macular Degeneration □ Retinal disease □ Other_____

Please list any eye related surgeries and dates:

_____

_____

Social History:

What is/ was your occupation?_____

Do you drink alcohol? □ Never
□ Occasionally □Socially □ Daily □Moderately □Heavy

Do you use tobacco? □ Never □ Quit When?_____
Cigarettes? How much?_____ □ Cigars? □ Chewing Tobacco

Family History: *Please check all that apply*
□ Glaucoma □ Macular Degeneration
□ Diabetes □ Cancer
Family members cause of death: _____

Medical History: *Please list all non-eye related surgeries and their dates*

_____

_____

_____

Name: DOB:

Medical History (continued): *Please check all that apply or none*

General: ☐ feel well ☐ unexplained weight gain/lose ☐ fever/chills ☐ fatigue

Other: _____ ☐ none

Skin: ☐ rosacea ☐ skin lesions ☐ itching ☐ rash

Other: _____ ☐ none

Cardiovascular: ☐ irregular heartbeat ☐ high blood pressure ☐ high cholesterol

Other: _____ ☐ none

Respiratory: ☐ sleep apnea ☐ COPD ☐ asthma ☐ wheezing

Other: _____ ☐ none

Gastrointestinal: ☐ heart burn ☐ IBS ☐ nausea ☐ diarrhea

Other: _____ ☐ none

Genitourinary: ☐ menopause ☐ prostate cancer ☐ kidney stones

Other: _____ ☐ none

Musculoskeletal: ☐ Lupus ☐ osteoporosis ☐ arthritis ☐ Sjogrens ☐ Rheumatoid Arthritis

Other: _____ ☐ none

Neurological: ☐ dementia ☐ migraines ☐ vertigo ☐ tremors

Other: _____ ☐ none

Hemato (blood)/Lymphatic: ☐ bruising ☐ swollen lymph nodes ☐ Sarcoidosis

Other: _____ ☐ none

Psychiatric: ☐ ADHD/ADD ☐ Anxiety ☐ depression

Other: _____ ☐ none

Endocrine: ☐ over/under active thyroid ☐ Diabetes ☐ diagnosed_____
☐ insulin use ☐ last blood sugar ☐ A1C_____

Other: _____ ☐ none

Women only: ☐ pregnant ☐ nursing

Allergies

Please list all allergies and reactions ☐ no known allergies

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Medications

Please list your medications, supplements, eye drops dosage and how often you take them

Example: Advil 200mg Twice daily

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

☐ no medications

Name_____ Date_____

Lifestyle Questionnaire

Here at **Fava & Maria Eye Associates**, we strive to provide the best quality of care and customized vision solutions for our patients. This questionnaire will assist us in providing the treatment best suited for your visual needs & lifestyle. Please fill this form out completely and return it to us. If you have and questions, please let us know and we will be happy to assist you.

- What are your favorite hobbies and/or daily activities?

  _____

  _____

- If you work, what are some of your daily work-related tasks?

  _____

  _____

- How much time, per day, do you spend on the computer?

  _____

  _____

- Does your work or livelihood require night-time driving?

  ____ Yes ____ No

- How important would it be for you to be free from glasses for your daily activities?

  ____ Very important ____ Moderately important ____ Not important

- How would you describe your personality?

  ____ Easy going ____ Perfectionist ____ In between

HAVE YOU HEARD ?

Hearing Professionals at Our Practice

Our practice has employed a Licensed Hearing Care Professional for the convenience of our patients. Did you know that everyone reads lips to some extent? Have you ever noticed that it is more difficult to understand a conversation when the person who is speaking has his/her back to you or their face covered? It's true, we read lips, so when our hearing starts to diminish as well as our vision, our quality of life is compromised. It is because of the strong connection between vision and hearing that our practice is pleased to announce our expanded hearing services for our patients. Please schedule your free Hearing Evaluation today.

Hearing SELF Evaluation TEST

Do you miss parts of conversations or always ask to have the television made louder? Have you been told by a loved one or friend that you need to have your hearing tested? If you are approaching 60 or older, you may benefit from a hearing evaluation. Please feel free to take our short HEARING SELF TEST to determine if like many others, you would benefit from a comprehensive and complimentary hearing evaluation.

1 **Do you experience ringing or noises in your ear?**
- ☐ YES
- ☐ NO

2 **Do you hear better with one ear than the other**
- ☐ YES
- ☐ NO

3 **Do you have difficulty following conversations in a noisy restaurant or crowded room?**
- ☐ YES
- ☐ NO

4 **Do you feel that people mumble or fail to speak clearly?**
- ☐ YES
- ☐ NO

5 **Do you have difficulty listening to the TV or radio?**
- ☐ YES
- ☐ NO

6 **Do you find it difficult to understand the speaker at a public meeting or religious service?**
- ☐ YES
- ☐ NO

7 **Does your difficulty hearing interfere with your personal, family or social life?**
- ☐ YES
- ☐ NO

If you answered yes to any of these questions you may benefit from a free hearing evaluation.
Using state of the art technology, we systematically perform a series of painless tests designed to predict the body's neurological and mechanical abilities to detect and amplify sound as well as determining your ability to interpret speech. The hearing test time is dependent on the amount of hearing loss and whether or not a hearing aid fitting needs to occur. For more information or to schedule a free hearing evaluation please see our receptionist or call **717-272-2010**

FAVA & MARIA EYE ASSOCIATES

FINANCIAL LIABILITY POLICY

875 Norman Drive
Lebanon, PA 17042
(717) 272-2010

It is the responsibility of the patient to provide us with current copies of insurance cards and all changes to your personal information needed to allow us to properly bill your insurance carrier.

Patient Responsibility:
Your insurance company will only pay for services that it determines to be "reasonable and necessary". If your insurance company determines that your visits and/or testing is "not" reasonable or necessary, based on their program standard,
YOU THE PATIENT ARE ULTIMATELY RESPONSIBLE FOR PAYMENT OF ANY SERVICE NOT COVERED BY YOUR INSURANCE.

Collection Costs: I accept full financial responsibility for payment of all services, testing, co-pays, coinsurances, deductibles, etc. that my insurance carrier does not fully cover. If you are unable to pay for the above at the time of service, a $15 administrative fee will be administered to your account to the cover the costs of generating a bill. In the event a personal check is returned "unpaid" from your bank, a $25 returned check fee will be charged to your account.
If your account goes into a "collection" status for non-payment, the patient will be responsible for all collection fees, including attorney costs, etc. associated with your account.

We accept: Cash, Checks, VISA, MasterCard, Discover, American Express + Care Credit

Telephone Call Disclosure:
In order for us to service your account or to collect any amounts you may owe, we may contact you by telephone. We may use any telephone and/or wireless telephone number, which could result in charges to you. We may also contact you by sending text messages or e-mails, using the e-mail address you have provided to us. Methods of contact may also include pre-recorded/artificial voice messages, or automatic dialing devices as applicable.

I have read the above financial policy of Fava & Maria Eye Associates; I understand that I am financially responsible for all charges whether or not paid by my insurance. I understand that my account may be turned over to a collection agency for non-payment.

I have read the Telephone Call Disclosure and fully agree to the terms and conditions of this policy as mentioned above.

PLEASE READ - WILL SIGN POLICY AT APPOINTMENT CHECK-IN

AUTHORIZATION TO USE or DISCLOSE HEALTH INFORMATION

Our Privacy Pledge

Fava & Maria Eye Associates and *Valley View Surgical Center* are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use to disclose your health information:

** If we refer you to another provider or hospital; we may have to disclose your health information to them for the diagnosis, assessment or treatment of your health condition.
** We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
** We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before your sign this consent form. We reserve the right to change our privacy policy as described in that notice. If we make a change to our privacy policy, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy policy.

Your Right to Limit Uses or Disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your Right to Revoke your Authorization

You make revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we already released your health information before receiving your revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received or have reviewed a copy of this medical practice's:

Authorization of Use or Disclose Health Information.

PLEASE READ - WILL SIGN POLICY AT APPOINTMENT CHECK-IN

6/2016