WESTERN CAROLINA EYE ASSOCIATES, P.A.
REGISTRATION FORM

(Please Print)

Today's date:			PCP:	
PATIENT INFORMATION				
Patient's last name: First: Middle:			❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Billing address:			Primary Address? ❑ Yes ❑ No	How did you hear about us?
City	State	Zip Code:		Date of Birth
Occupation:	Employer:			Employer phone no.: ( )
Please check your preferred method of contact: Home #: ❑ ( ) Cell: ❑ ( )			Email Address: ❑	
Other family members seen here:				

INSURANCE INFORMATION			
(Please give your insurance card to the receptionist. Only enter info if it is different from info entered above)			
Is this patient covered by insurance? ❑ Yes ❑ No Is this person responsible for the bill a patient here? ❑ Yes ❑ No			
Subscriber/Person responsible for bill:	Birth date: / /	Address:	Home phone no.: ( )
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other			

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

Medical and Vision Insurance

We are only contracted with the Following plans listed below; please check the plan you currently carry.

- **Medical Plans** : ❑ Medicare (Red, White and Blue Card) ❑Medicaid/Carolina Access ❑ BCBS Plans ❑Medcost ❑United Healthcare ❑Blue Medicare HMO
- **Vision Plans**: ❑ Community Eye Care ❑Superior Vision ❑VSP

We do not accept HMO plans (except blue Medicare). Medicare plans forward to your secondary plan, if not, we will file as a courtesy. We file Tricare as a courtesy.

You must have a referral from your Primary Care Physician before your appointment if you have Tricare Prime.

Please sign to confirm you carry the plan indicated on this form. Last Revised 5/1/17

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any unpaid balance and non-covered services as reported by my insurance. This includes but is not limited to Refractions and special testing. I authorize Western Carolina Eye Associate, PA or insurance company to release any information required to process my claims.

Western Carolina Eye Associates
Patient History

Name:_____ Date of Birth:_____/_____/_____

Medications you currently take, including Eye Drops (Attach a copy if necessary):

_____ _____ _____

_____ _____ _____

_____ _____ _____

Allergies/Drug Allergies: _____ _____ _____

_____ _____ _____ _____

Please check all that apply in the following lists:

Your Family Eye History: Relation:

Diabetes: ☐ _____

Cataracts: ☐ _____

Glaucoma: ☐ _____

Macular Degeneration: ☐ _____

Retinal Detachment: ☐ _____

Other: _____

_____

Your Eye History
(Previously or currently being treated):

Glasses/contacts: ☐

Lazy eye: ☐

Cornea problems: ☐

Cataracts: ☐

Glaucoma: ☐

Retinal problems: ☐

Macular degeneration: ☐

Eye injuries/surgeries: ☐

Dry Eyes ☐

Social History: frequency:

Tobacco ☐ _____

Alcohol: ☐ _____

Caffeine: ☐ _____

Your History:

High Blood Pressure: ☐

Diabetes: ☐

Thyroid Disorders: ☐

Headaches/Migraines: ☐

Seasonal Allergies: ☐

Your Eye Symptoms
(Experienced in the last month):

Blurred, distorted, loss of vision: ☐

Glare or light sensitivity: ☐

Discharge or excess tearing: ☐

Burning, dryness, itching: ☐

Drooping eyelid: ☐

Double vision: ☐

Flashes of light or floaters: ☐

Redness: ☐

Foreign body sensation: ☐

Pain or soreness: ☐

Stye or chalazion: ☐

Infection of eye or lid: ☐

Crossed or lazy eye: ☐

Please List any Past Surgeries:

Surgery Type:	**Date:**
_____	_____
_____	_____
_____	_____
_____	_____

OTHER INFO:

_____

_____

_____

_____

_____

Western Carolina Eye Associate, PA

Privacy Practices and Shared Information Agreement

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

Notice of Privacy

Please review WCEA Notice of Privacy Agreement which adheres to HIPAA guidelines.
The Patient understands that:

- Protected health information may be disclosed or used for treatment, payment or healthcare operations.
- WCEA has a Notice of Privacy Practices and any patient may review it anytime.
- WCEA reserved the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information but WCEA does not have to agree to those restrictions.
- The patient may revoke this consent in writing at any time and all future disclosures will then cease. However such revocation shall not affect any disclosures we have already made in reliance on your prior consent.
- WCEA may condition treatment upon the execution of this consent.

Shared Information Agreement

Many of our patients allow family members such as their spouse, parents or friends to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must sign this form. Signing this form will only give information to family members indicated below. I authorize Western Carolina Eye Associates, P.A. to release my medical and/or billing information to the following individual(s):

1. _____ Relation: _____ ☐ Billing ☐ Medical
2. _____ Relation: _____ ☐ Billing ☐ Medical
3. _____ Relation: _____ ☐ Billing ☐ Medical

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed. I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to re-disclose by the above recipient. You have the right to revoke this consent in writing.

I acknowledge that I have received a Notice of Privacy Practices and the Shared information Agreement in accordance with HIPPA guidelines. I agree to the terms and conditions listed above.

_____ _____

Patient/Guardian Signature Date