HAYDEN VISION

REGISTRATION FORM

Today's Date: _____

Name	**Date of Birth**		**Gender**
Address	**City**	**State**	**Zip**
Best Phone Is this: Cell Home Work		**SSN**	
Best Email	**Employer**		
Name of Insured		**Relationship**	
Emergency Contact		**Phone**	
Primary Care Doctor	**Optometrist**		
Pharmacy	**City**	**Phone**	

ASSIGNMENT OF BENEFITS: I request that payment of authorized benefits be made either to me or on my behalf to Hayden Vision for services furnished to me by Hayden Vision providers. I authorize any holder of medical information about me be released to the insurer and its agents as needed to determine benefits payable for related services.

RELEASE OF INFORMATION: Hayden Vision may disclose all or any part of my medical record and/or financial ledger including alcohol or drug abuse, psychiatric illness, communicable disease, or HIV to any person or corporation 1) which is or may be liable or under contract to Hayden Vision for reimbursement of services rendered; 2) any healthcare provider for continued patient care; 3) Family members unless otherwise indicated by the patient. ***DO NOT release medical information to***: _____

FINANCIAL AGREEMENT: I agree that in return for services provided by Hayden Vision, I will pay any amount my insurance does not cover, including deductibles and/or co-payments at the time that services are rendered, or I will make arrangements that day satisfactory to Hayden Vision. If my account is sent to a collection agency, I agree to pay reasonable collection expenses. It is understood that the undersigned and/or patient are primarily responsible for payment of my bill.

SELF PAY PATIENTS: Payment is expected at the time of service unless other financial arrangements have been made prior to your visit. Send an itemized receipt with your claim to your insurance carrier who will reimburse you directly.

CO-PAYMENTS: By law we must collect your co-pay at the time of service. Please be prepared to pay this copay at each visit.

NON-COVERED SERVICES: I understand that Hayden Vision contracts with healthcare service plans for services covered by these plans. Accordingly, the undersigned accepts full financial responsibility for all items or services.

REFRACTIONS: A refraction fee of $45.00 is the responsibility of the patient. Insurance considers this a non-medical charge and therefore it is not covered under private insurance, Medicare, or Medicaid benefits.

Signature of Patient or Insured: _____

HAYDEN VISION

HEALTH HISTORY

New Patient

NAME _____ **TODAY'S DATE** _____

OCULAR HISTORY	YES	NO		YES	NO		YES	NO
Allergic Conjunctivitis			Glaucoma			Retinal Tear		
Blepharitis			Macular Degeneration			Retinal Detachment		
Cataract			Macular Pucker			Strabismus (Lazy Eye)		
Fuchs Corneal Dystrophy			Narrow Angles			Vitreous Detachment		
Diabetic Retinopathy			High Eye Pressure			Other?		
Dry Eyes			Ocular Migraine					

OCULAR SURGERY	R	L		R	L		R	L
Cataract Surgery			Glaucoma Laser			Retinal Tear		
Corneal Transplant			Eyelid Surgery			Retinal Detachment		
Eye Muscle Surgery			Punctal Plugs			Strabismus (Lazy Eye)		
Eye Injections			Strabismus Surgery			Vitreous Detachment		
LASIK			Retinal Laser			Other?		
PRK			Trabeculectomy					

FAMILY HISTORY	YES	NO	FAMILY MEMBER?		YES	NO	FAMILY MEMBER?
Blindness				Retinal Detachment			
Glaucoma				Macular Degeneration			

SOCIAL HISTORY				
Cigarettes	Never	Quit	Occasional	Daily
Alcohol	None	Less than daily	1-2 drinks per day	3+ drinks per day
Occupation				

Please turn page over

MEDICAL HISTORY	
Medications (list here or provide us a list):	Allergies (list or write “none”):
Significant medical conditions? (list)	Significant surgeries? (list)

RECENT CHANGE IN OVERALL HEALTH	**YES**	**NO**		**YES**	**NO**
Fever			Active seasonal allergies		
Uncontrolled blood sugar			Arthritis flare-up		
Chest pain			Depression		
Numbness or burning in feet			Anxiety		
Chemotherapy or radiation treatments			COVID		

How did you hear about our practice? _____