

ZEITER EYE MEDICAL GROUP, INC.
PATIENT INFORMATION

Date _____ Home Phone _____ Cell Phone _____
Name _____ Soc. Sec. # _____
Last First Initial
Address _____ Dr. Lic. # _____
City _____ State _____ Zip _____
Sex M F Age _____ Birthdate _____ Single Married Widowed Separated Divorced
Patient Employed by: _____ Occupation _____
Employer Address _____ Employer Phone _____
In case of emergency who should be notified? _____ Phone _____

COMPLETE THE FOLLOWING IF MARRIED

Spouse's Name _____ Birthdate _____ Soc. Sec. # _____
Employer _____ Occupation _____
Employer Address _____ Employer Phone _____

COMPLETE THE FOLLOWING IF PATIENT IS A MINOR

Father's Name _____ Birthdate _____ Soc. Sec. # _____
Address _____ Home Phone _____ Dr. Lic. # _____
Employer _____ Employer Phone _____
Employer Address _____
Mother's Name _____ Birthdate _____ Soc. Sec. # _____
Address _____ Home Phone _____ Dr. Lic. # _____
Employer _____ Employer Phone _____
Employer Address _____

HOW DID YOU HEAR ABOUT US? Please check all that apply:

- | | | |
|---|--|--|
| <input type="checkbox"/> Web Site | <input type="checkbox"/> Lodi News Sentinel | <input type="checkbox"/> Friend _____
<small>Name</small> |
| <input type="checkbox"/> Spanish Television | <input type="checkbox"/> Church Bulletin | <input type="checkbox"/> Relative _____
<small>Name</small> |
| <input type="checkbox"/> English Cable T.V. | <input type="checkbox"/> Retirement Home | <input type="checkbox"/> Doctor _____
<small>Name</small> |
| <input type="checkbox"/> Stockton Record | <input type="checkbox"/> Today's Senior Magazine | <input type="checkbox"/> Other _____
<small>Name</small> |

REVIEW OF SYSTEMS (check box if pertinent):

- | | | |
|---|---|---|
| <input type="checkbox"/> Ear, nose or throat disease | <input type="checkbox"/> Urinary tract disease | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Arthritis or Muscle disease | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Asthma or other lung disease | <input type="checkbox"/> Stroke or other neurologic disease | <input type="checkbox"/> Psychiatric or Mental Conditions |
| <input type="checkbox"/> Gastrointestinal disease | | |

MEDICATIONS (including eye medications):

MEDICAL HISTORY:

What trouble are you having with your eyes? _____

For how long? _____ When was your last eye examination? _____

Check any signs or symptoms that you have:

- | | | | | |
|--|--|--------------------------------------|---|--|
| <input type="checkbox"/> blurry vision | <input type="checkbox"/> eye discharge | <input type="checkbox"/> eye pain | <input type="checkbox"/> crossed eyes | <input type="checkbox"/> floaters (strings, shadows) |
| <input type="checkbox"/> double vision | <input type="checkbox"/> red eye | <input type="checkbox"/> itching eye | <input type="checkbox"/> flashes of light | |

Do you wear glasses/contact lenses? _____ When did you receive your last pair? _____

Have you ever had any eye surgery? _____ What for and when? _____

Are you allergic to any medications? _____

Family physician: _____

INSURANCE INFORMATION

Primary Ins. _____

Subscriber Name _____ Birthdate _____ Soc. Sec. # _____

Policy/ID No. _____ Group _____

Secondary Ins. _____

Subscriber Name _____ Policy/ID No. _____ Group No. _____

VISION PLAN

VISION SERVICE PLAN (VSP) _____ MEDICAL EYE SERVICE (MES) _____ OTHER _____

HAVE YOU SIGNED YOUR MEDICARE BENEFITS OVER TO ANY OF THE FOLLOWING MEDICARE RISK PROGRAMS? _____ (IF SO, WHICH ONE?) KAISER _____ SECURE HORIZONS/PACIFICARE _____

The insurance information I have given is accurate. I understand that it is my responsibility to notify ZEITER EYE if any change in insurance coverage takes place. I realize that by withholding the correct insurance information, including required authorizations or referrals, I become liable for payment should my claim be denied.

Patient or Guardian Signature

Date

Please present your insurance card to the front counter to be photocopied. If your insurance company requires a referral form, please present it to the receptionist.

Medical Eye Services of California, and Vision Service Plan Sight For Students, require their own completed claim form. Please have these available.

CLAIM AUTHORIZATION

I request that payment of authorized Health Insurance benefits (including Medicare) be made either to me or on my behalf to ZEITER EYE MEDICAL GROUP, INC. AND AMBULATORY SURGICAL CENTER OF ZEITER EYE for any services furnished to me by that group. I authorize any holder of medical information about me to release to the Health Care Financing Administration or to my Health Insurance carrier any information needed to determine these benefits or the benefits payable to related services.

I UNDERSTAND THAT MY SIGNATURE REQUESTS THAT PAYMENT BE MADE AND AUTHORIZES RELEASE OF MEDICAL INFORMATION NECESSARY TO PAY THE CLAIM. If a claim form is submitted, my signature authorizes release of the information to the Insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. The coinsurance and deductible are based upon the charge determination of the Medicare carrier. I also understand that Medicare will not cover the refraction portion of my eye examination. Therefore, I accept responsibility for payment.

Patient Signature

Date

FINANCIAL POLICY

We will bill all insurances as a courtesy to our patients. If you have no insurance we ask that payment be made at the time of service.

WE GLADLY ACCEPT MASTERCHARGE, VISA OR AMERICAN EXPRESS.

**CO-PAYS AND DEDUCTIBLES
ARE DUE AT TIME OF SERVICE**