Vistasight Optometric Center
Patient Registration Form

Date ___________________

Personal Information:

Patient Name ____
First Name MI Last Name

☐ Single
☐ Married
☐ Widow/Divorced

Social Security Number ______________________ M/F _____ DOB _________________ Age _____

Mailing Address ____________________________ City _________________ State _____ Zip ______

Home Phone ___________________ Cell Phone ___________________ Work Phone __________________

Employer _________________________________ Occupation ____________________________________

Family Physician ____________________________ Referred By __________________________________

Emergency Contact __________________________ Relationship _____________ Phone ______________

Which primary phone number may we use for correspondence? (Circle **ONE**) Home Cell Work

Insurance Information:

Primary Insurance ____________________________________ Insured's SSN/ID# ____________________

Insured's Name ______________________________________ Insured's DOB _______________________

Insured's Address (if different than above) ____

Insured's Phone (if different than above) ___________________ Relation to Patient _____________________

Secondary Insurance __________________________________ Insured's SSN/ID# ____________________

Insured's Name ______________________________________ Insured's DOB ______________________

Insured's Address (if different than above) ____

Insured's Phone (if different than above) ___________________ Relation to Patient _____________________

Financial Assignment and Insurance Authorization:

I authorize payment of insurance benefits to Michael D. Neunzig, O.D./Vistasight Optometric Center for professional services rendered. I authorize release of any and all information necessary to process my insurance claim. This assignment will remain in effect until revoked by me in writing.

Signature____ Date _______________
Patient (or Parent/Guardian if patient under 18 years of age)

Vistasight Optometric Center
Medical History Form

Name of Patient ______________________________ Date ________________

List any **EYE** conditions you have (e.g. cataracts, macular degeneration, glaucoma, retinal problems, etc):

List any **EYE SURGERIES OR INJURIES** you have had and when (e.g. cataract, photorefractive, retina, etc):

List any **MEDICAL** conditions you have (e.g. diabetes, high blood pressure, arthritis, thyroid problems, etc):

List any **MEDICATIONS** you take (If none, list "none"):

List any **MEDICATION ALLERGIES** you have (If none, list "none"):

Do you have **any** of the following problems:

			If yes, explain:
Allergic/Immunological (e.g. environmental allergies, lupus, RA)	N	Y	
Musculoskeletal (e.g. fibromyalgia, muscle/joint aches, arthritis)	N	Y	
Cardiovascular (e.g. heart disease, chest pain, irregular heartbeat)	N	Y	
Gastrointestinal (e.g. heartburn, diarrhea, ulcers, abdominal pain)	N	Y	
Neurological (e.g. epilepsy, MS, Alzheimer's, Parkinson's)	N	Y	
Constitutional (e.g. fever, unexpected weight loss/gain, fatigue)	N	Y	
Genitourinary (e.g. bladder infections, prostate problems, STDs)	N	Y	
Psychiatric (e.g. depression, panic disorder, schizophrenia)	N	Y	
Ear/Nose/Throat (e.g. sore throat, tinnitus, sinus problems)	N	Y	
Hematological/Lymphatic (e.g. anemia, clotting issues, leukemia)	N	Y	
Respiratory (e.g. asthma, COPD, emphysema, bronchitis)	N	Y	
Endocrine (e.g. thyroid dysfunction, diabetes)	N	Y	
Integumentary/Skin (e.g. rashes, rosacea, psoriasis, eczema)	N	Y	

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Medical History Form
(continued)

Do you smoke? (Circle one)	Never	Former	Some days	Everyday
Do you drink alcohol? (Circle one)	Never	Rarely	Occasionally	Frequently
Do you drink caffeine? (Circle one)	Never	Rarely	Occasionally	Frequently

For Females Only: Are you pregnant? N Y Are you nursing? N Y

When was your last eye examination? __________________ Doctor's Name ______________________________

When was your last physical exam? ____________________ Doctor's Name ______________________________

Do any of your **direct family members** (father, mother, siblings, children, grandparents) have any of the following conditions (if so, who?):

Glaucoma ________________ Macular Degeneration _________________ Retinal problems ________________

Lazy Eye _________________ Cataracts _____________________________ Color Blindness ________________

Diabetes _________________ High Blood Pressure __________________ Thyroid Problems _______________

Do you currently wear glasses? N Y If so, what type? ______________________________

Do you currently wear contact lenses? N Y If so, what brand? _____________________________

Other important information (include additional medical/social history, hobbies, special visual needs, etc):

____

____

____

Signature of Patient or Parent/Guardian ___________________________________ Date ____________________

___________________________________ Do Not Write Below This Line _____________________________________

☐ Reviewed by Optometrist ____ Date _____________________

Comments: ____

Vistasight Optometric Center
Acknowledgment of Receipt of Notice of Privacy Practices

Vistasight Optometric Center
891 Sunset Drive
Hollister, CA 95023
Telephone: (831) 637-7471
Privacy Officer: Michael D. Neunzig, O.D.

I hereby acknowledge that I have received a copy of this practice's Notice of Privacy Practices. I further acknowledge that a copy of this practice's Notice of Privacy Practices is posted on the wall for review at my convenience, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

I consent to the use and disclosure of my health information for purposes of treatment, payment, and health care operations.

Printed name of patient: ____

Signature____________________________________ Date _______________

Printed Name ________________________________ Phone: ______________

If signing as a personal representative of the patient, please indicate relationship to patient:

- ☐ Parent or legal guardian of minor patient
- ☐ Guardian or conservator of an incompetent person
- ☐ Beneficiary or personal representative of deceased patient

Vistasight Optometric Center
Financial Policy

Please be sure to bring your insurance card with you to every visit and let the receptionist know of any changes. Payment in full is due at the time of service, unless we are contracted with your insurance company. If we have a contract with your insurance, it is required that we collect your co-payment upon check-out. If you are unable to pay the required fees at the time of service, our receptionist will gladly reschedule your appointment for a later date.

If we have a contract with your insurance company, we will submit the claim to your insurance. Some services may not be covered by your insurance company. In this case, you would be responsible for the whole charged amount. If, upon submitting a claim to your insurance company you are later deemed to be uncovered for services rendered, you will be responsible for the balance.

Many insurance plans, including Medicare, do not cover routine examinations or refractions (the measurements necessary to determine glasses or contact lens powers). If you have a separate vision plan to cover these services, please let our receptionist know. Otherwise, payment is due at the time of service.

If you plan to use an insurance for which we are not providers or are not on the provider panel, we can provide you with an itemized receipt of services so you can submit it to your insurance company for reimbursement. In this case, full payment is due to us at the time of service and your insurance company will reimburse you (instead of us) directly for any covered amounts.

I have read and understand the Financial Policy.

Signature: ____ Date: ___________