VISION ARORA

6500 Greenville Ave, Suite# 150 Dallas TX 75206 PHONE # 469-444-2020

PATIENT REGISTRATION FORM

Today's Date: _____/____/_____ _____New Patient _____Previous Patient

PATIENT INFORMATION

Patient Name: (Last, First) _____Nickname: _____**Date of birth**: ____/_____/____
Guardians Name: (if patient is below 18 years of age) _____
Home address: _____Apt#_____
City: _____State:_____ZIP:_____
Gender: MALE FEMALE **Social Security #** _____
Cell Phone#_____Text (For Appointment reminder only): YES NO
Home Phone#_____ Work Phone#_____
Email Address: _____
Occupation: _____Employer: _____
Referred by: Friend Doctor Insurance Co. Walk-in Mailer Google Yelp Facebook
Referring person's name: _____

INSURANCE INFORMATION

Are you the primary on the insurance? YES- I AM THE PRIMARY NO- I AM NOT THE PRIMARY
IF NO ANSWER THE FOLLOWING: Relationship to Primary SPOUSE CHILD OTHER_____
Primary Card Holder Name: _____ **Primary DOB**: _____/_____/_____
Primary Address: _____**Primary Social Security #** _____-_____-_____
Primary Phone # _____ Primary Employer: _____
Medical Insurance Name: _____Secondary Insurance Name: _____
Vision Insurance Name: _____Medicaid #_____ Medicare # _____
Insurance ID # _____**Policy/ Group #** _____
Person Responsible for payment (if patient is a minor): _____

REASON FOR EYE EXAM

Primary reason for today's visit: _____
Date of last eye exam: _____/_____/_____ Previous Eye Doctor: _____
Which of the following problems are you noticing (please circle all that apply):

Blurred Distance Vision	Watery Eyes	Headaches	Glare
Blurred Near Vision	Dry Eyes	Eyestrain	Flashes/floaters/shadows
Night Vision Difficulty	Burning Eyes	Eye fatigue	Light Sensitivity
Double Vision	Itchy Eyes	Eye turning in/out	

Are you interested in Laser Vision Correction? YES NO

CONTACT LENS HISTORY:

Do you wear contacts? NO YES BRAND- CONTACTS_____ BRAND- SOLUTION_____
Are you happy with current contacts YES NO (Reason?)_____
How old are your current contacts? _____Do you replace or dispose your lens? _____
What is your typical wearing schedule? _____

GLASSES HISTORY:

What glasses do you wear? Single vision Bifocal Progressive Trifocal Sports Glasses Sunglasses Safety glasses
Work on a Computer? NO YES How many hours/day_____
How many inches away do you sit from the monitor? _____

Patient Name: _____Date of Birth: _____/_____/_____

OCULAR HISTORY			SELF	FAMILY	**MEDICAL HISTORY**			SELF	FAMILY
Diabetic Retinopathy	NO	YES			Diabetes	NO	YES		
Glaucoma	NO	YES			High Blood Pressure	NO	YES		
Macular Degeneration	NO	YES			High Cholesterol	NO	YES		
Retinal Dz/Detachment	NO	YES			Thyroid Issues	NO	YES		
Cataract	NO	YES			Cardio Vascular Disease	NO	YES		
Amblyopia/lazy eye	NO	YES			Rheumatoid Arthritis	NO	YES		
Blindness	NO	YES			Sleep Apnea	NO	YES		
Laser Eye Surgery	NO	YES			HIV Positive	NO	YES		
Eye Surgeries	NO	YES			Cancer	NO	YES		
Eye Injury	NO	YES			Women: Pregnant	NO	YES		
Eye Infection	NO	YES			Women: Nursing	NO	YES		

EXPLAIN:_____

_____

MEDICATIONS LIST ALL MEDICATIONS CONSUMED

Medications/Supplements NO YES_____

Eye Drops NO YES_____

Contact lens Solution NO Opti-free Biotrue Clear Care Renu Generic Other_____

ALLERGY HISTORY LIST THE ALLERGIES

Seasonal/Food Allergies NO YES_____

Medication Allergies NO YES_____

Allergy to contact lens solution NO YES_____

SOCIAL HISTROY

Cigarette Smoker Never Current Former/stopped_____

Use of Other Substance Never Current Former/Stopped_____

Alcohol? None/rare <1 drink/day >1 drink/day_____

NOTICE OF PRIVACY PRACTICES CONSENT

I acknowledge that I have read and reviewed the Notice of Privacy Practices. The information I provided here will be used only for the diagnosis, treatment, and/or payment for healthcare purposes.

SIGNATURE: _____ **DATE:** _____/_____/_____

VISION ARORA FINANCIAL RESPONSIBILITY

Thank you for choosing Vision Arora for your eye care needs. We are happy to serve you and look forward to serving you in the future as our valued patient. We strive to keep an open communication with all our patients by proving accurate information regarding their insurance and financial responsibility, so you can be sure your claims will be handled promptly and efficiently. Our office will, as a courtesy, file your insurance claims based on the information you provided on the registration form. It is your responsibility to provide us with complete and accurate information, failure of which will result in a denied claim. If a claim is denied, it becomes your responsibility to pay the balance in full. If insurance information is not provided on the date of service, we **do not** file claims later. **By signing below, you understand that you will be ultimately responsible for the payment of any services not paid by your insurance company which includes co-pays, deductibles, co-insurance, non-covered services, and denied services not covered by contract by our office and your insurance company.** We will assist you in all possible ways to ensure that the claims are filed timely and properly. We will send reminder statements and invoices if there is a balance to be paid by you. If deemed necessary, we reserve the right to send uncollected claims after three reminder statements to a collection agency.

Vision Arora requires that all exam fees and co-pays be paid in full at the time of service and a deposit of at least 50% be made when ordering materials. **ALL PROFESSIONAL SERVICES ARE NON REFUNDABLE**.

Thank you for your cooperation and for choosing Vision Arora!

SIGNATURE: _____**DATE:** ____/_____/_____