ASCEND EYE CENTER
ADVANCED EYE CARE & SURGERY

755 Highland Oaks Drive, Ste 202
Winston Salem, NC 27103

Phone (336) 997-4599
www.ascendeye.com

NEW PATIENT REGISTRATION

Referred by:_____ Family doctor:_____

Name.(Last, First)_____ Date of birth_____

Home Address_____ Age _____

City_____ State_____ Zip Code_____ Gender M F

Home Phone_____ Cell Phone_____ Marital Status _____

E-mail _____ Social Security #_____

Employer/Parent's Employer_____ Occupation_____

Work Address_____ Work Phone_____

City_____ State_____ Zip Code_____

Spouse name (Parent if minor)_____ Spouse/Parent Phone_____

Additional emergency contact_____ Relationship_____

Phone number(s)_____ ☐ Permission to leave messages with medical information

Primary Insurance Company		
ID#	Group #	Effective Date
Subscriber Name		**Relationship to Patient**
Social Security Number	Date of Birth	Employer

Secondary Insurance Company		
ID#	Group #	Effective Date
Subscriber Name		**Relationship to Patient**
Social Security Number	Date of Birth	Employer

I certify that I (or my dependent) have insurance coverage as stated above. I certify that my responses on this form are accurate to the best of my knowledge I agree to have insurance payments directly made to Ascend Eye Center to apply to my account for services rendered. I understand that I am financially responsible for all charges incurred in the event that my insurance denies payment. I am aware there may be additional collection and/or attorney's fees if my account is referred for collection.

Signature of Patient or Personal Representative (Relationship to patient) Date

Patient Name | **Date of Birth** | **Height** | **Weight**

Do you wear glasses: Y / N Do you wear contact lenses: Y / N **We do not prescribe contact lenses or fit glasses**

Smoking_____ Alcohol_____ Drug use_____

Past Surgery_____

Allergies_____

Medical History	Yourself	Family Member		Yourself	Family Member
Glaucoma			Cancer/Type/Location		
Crossed or "Lazy" Eyes			Low Blood Pressure (< 100/60)		
Macular Degeneration	☐ Injection		Low Heart Rate (<60 beats/min)		
Retinal Detachment			Anemia (low blood count)		
High Blood Pressure			Migraine Headaches		
Diabetes			Sleep Apnea		
Heart Attack/Disease			Raynaud's phenomenon		
Stroke			Autoimmune Disease		
Thyroid Disease			(i.e. Lupus, Rheumatoid arthritis)		
Kidney Disease			Other		

Medication Name	Dosage	Medication Name	Dosage

Review of Systems:

1. Constitutional: ☐ Fever ☐ Chills ☐ Fatigue ☐ Unexpected weight loss ☐ Loss of appetite
2. Integumentary: ☐ Acne ☐ Rash ☐ Moles ☐ Itching
3. Eyes: ☐ Blurry vision ☐ Double vision ☐ Foreign body sensation ☐ Frequent watering ☐ Light sensitivity
4. HENT: ☐ Hearing loss ☐ Sinus congestion ☐ Sore throat ☐ Nasal Discharge ☐ Dental problems
5. Respiratory: ☐ Cough ☐ Shortness of breath ☐ Wheezing ☐ Coughing blood
6. Cardiovascular: ☐ Chest pain ☐ Irregular heartbeat ☐ Palpitations
7. Gastrointestinal: ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Heartburn/Reflux ☐ Blood in stools
8. Genitourinary: ☐ Incontinence ☐ Frequent urination/urgency ☐ Urinary pain ☐ Blood in urine
9. Endocrine: ☐ Hair loss ☐ Hot flashes ☐ Cold or heat intolerance ☐ Increased thirst ☐ Excessive body hair
10. Heme-Lymph: ☐ Easy bruising ☐ Clotting/bleeding disorder ☐ Enlarged lymph nodes
11. Musculoskeletal: ☐ Muscle pain ☐ Joint pain ☐ Joint swelling ☐ Abnormal spine curvature
12. Neurologic/Psychiatric: ☐ Numbness/Tingling ☐ Dizziness ☐ Memory loss ☐ Headache ☐ Depression ☐ Anxiety

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Acknowledgement of Pharmacologic Dilation:

We recommend a DILATED EXAMINATION as a baseline for new patients, for most diabetics and glaucoma patients, for certain other symptoms, and for established patients at certain reasonable intervals. This testing involves eyedrops that temporarily enlarge your pupils. Side effects include sensitivity to light and blurred near vision, expected to last approximately 4-24 hours in most patients.

☐ YES I understand the side effects of pupil dilation and agree to this procedure on my first appointment.

☐ NO I prefer not to have my pupils dilated on my first appointment, even if it is recommended by my eye doctor.
I understand the risk that I could have diseases which remain undetected if I refuse dilated examination.
I understand that I should return for dilated exam at another appointment as recommended by my eye doctor.

Acknowledgement of Cancellation Policy:

We ask that you provide at least 24 hours of notice if you are unable to keep your scheduled appointment. If your arrival is more than 15 minutes late for your scheduled appointment, we may need to reschedule your appointment. You may be subject to a fee of $50.00 for missed appointments. Multiple repeat occurrences may result in dismissal from our practice.

Acknowledgement of Refraction Services and Fees:

A refraction is the process to determine your best corrected vision and is necessary to write a prescription for eyeglasses. It is typically covered by a "vision plan," but NOT covered by Medicare or most medical insurance plans. We do not participate with vision service plans. Our office fee for refraction is $40.00. This fee is collected at the time of service in addition to any co-payment with your plan.

Acknowledgement of Payment Policy:

I hereby assign all medical benefits, including all major benefits to which I am entitled including Medicare, private insurance, and any other health plans, to Ascend Eye Center, LLC. A photocopy of this assignment is considered as valid as an original. I authorize said assignee to release all information necessary to secure the payment. If my insurance company has not reimbursed Ascend Eye Center within 60 days, I may be billed for any services or products that I have received. I understand that I am responsible for the balances due after billing. A late fee of $10.00 may be charged if I do not pay my balance within 30 days after receiving my statement.

Acknowledgement of Notice of Privacy Practices:

I have received the opportunity to review Ascend Eye Center's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, and the practice's legal duties with respect to my protected health information. The Notice includes:

- ⇒ A statement that this practice is required by law to maintain the privacy of protected health information.
- ⇒ A statement that this practice is required to abide by the terms of the notice currently in effect.
- ⇒ Types of uses and disclosures that this practice is permitted to make for treatment, payment, and health care operations.
- ⇒ A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- ⇒ A description of uses and disclosures that are prohibited or materially limited by law.
- ⇒ A description of other uses and disclosures made only with my written authorization and that I may revoke such authorization.
- ⇒ Notification that the members at Ascend Eye Center may access my claims medical history through an electronic service until I revoke my consent. I understand that my consent can be revoked at any time. Revocation must be made in writing.
- ⇒ My individual rights with respect to protected information and a brief description of how I may exercise these rights in relation to:
  - o The right to complain to this practice and to the Secretary of Health and Human Services (HHS) if I believe my privacy rights have been violated and that no retaliatory actions will be used against me in the event of such a complaint.
  - o The right to request restrictions on certain uses and disclosures of my protected health information and that this practice is not required to agree to a requested restriction.
  - o The right to receive confidential communications of protected health information.
  - o The right to inspect and copy protect health information.
  - o The right to amend protected health information.
  - o The right to receive an accounting of disclosures of protected health information.
  - o The right to obtain a paper copy of the Notice of Privacy Practice from this practice upon request.

This practice reserves the right to change the terms of its Notice Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain Ascend Eye Center's current Notice of Privacy Practice on request.

_____ _____ _____
Patient Name (Print) Date of Birth Date of Signature

_____ _____
Signature of Patient or Personal Representative Relationship to Patient if signing for Patient