New Patient Registration

Please fill out this form so we can know you better!

Tomoka Eye Associates

PERSONAL INFO

PATIENT NAME		DOB:	**Appt Date & Time**
Local Mailing Address		SSN:	
City/State/Zip Code		Home Phone #	
Alternate Address		Cell Phone #	
City/State/Zip Code		Sex ☐ Male ☐ Female	Marital Status M D S W
Retired? ☐ Y ☐ N	Employer	Spouse's Name	
Occupation		Referred by	
Preferred Language		Email Address	
ETHNICITY: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino	RACE: ☐ White/Caucasian ☐ Asian	☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander	☐ Native American/Alaska Native ☐ Other:
Emergency contact (other than spouse):		Do you give permission to TEA to advise family members of medical status?	
Relationship		Relationship	
Phone #		Phone #	INITIAL

MINOR

IF THE PATIENT IS A MINOR, PLEASE FILL OUT THE FOLLOWING INFORMATION.
A minor is defined as any patient who is under the age of 18. The person bringing the minor in to the appointment is responsible for the account, regardless of custody and/or insurance policy holder information. (Must bring custody papers or notarized permission notice if other than parent.)

Responsible Adult Name	Date of Birth	Sex M F
Relationship	Social Security #	
Address if different from above	Mother's Name	Phone #
City/State/Zip Code	Father's Name	

INSURANCE INFORMATION

Tomoka Eye Associates participates with Medicare and many other insurance networks. It is ultimately the patient's responsibility to ensure network participation with the insurance company. TEA cannot assume responsibility for network participation. Please provide a photo ID and insurance cards to receptionist.

Primary Insurance Co.	Policy Holder (if other than patient)
Policy Number	Relationship to Patient
Group Number	Date of Birth
Secondary Insurance Co.	Policy Holder (if other than patient)
Policy Number	Relationship to Patient
Group Number	Date of Birth

I certify the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to be released to the Social Security Administration or its intermediaries/carriers for any related Medicare or other insurance claim. I request the payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician/organization furnishing the services or authorize such physician/organization to submit a claim to Medicare or other insurance for payment to me. We file clams to Medicare and most insurance plans. As a courtesy, we will file secondary insurances. If the payment is not received within ninety days, you will be billed. If incorrect insurance information is provided to us, we will be unable to file a claim after 90 days from the date of service. All professional services are the patient's responsibility regardless of insurance coverage. You are expected to pay for any DEDUCTIBLES, CO-PAYMENTS, & NON-COVERED SERVICES at the time of service. We accept cash, checks, Visa, MasterCard, Discover, and American Express. I verify the information provided is true and accurate. I understand it is my responsibility to notify TEA of any changes to the information provided.

SIGNATURE

SIGNATURE	**DATE**
RELATIONSHIP (if other than patient)	**REASON (if unable to sign)**

TEA POLICIES

Tomoka Eye Associates

HIPAA POLICY

I acknowledge I have received access notification to the modified HIPAA privacy practices, security, enforcement, and breach notification rules under the Health Information Technology for Economic and Clinical Health Act and the Genetic Information Nondiscrimination Act for Tomoka Eye Associates & Tomoka Optical effective September 23, 2013. (The entire policy can be viewed at HTTP://TOMOKAEYE.COM. Click on the HIPAA link. A CD-ROM version is available by request.)

Initial ____________

TEA REFRACTION POLICY

In Ophthalmology, the refraction is a clinical test used to determine the eye's refractive error and the best corrective lenses to be prescribed. This is a necessary part of the medical exam to provide the sharpest, clearest vision. In most cases, the refraction is required for continuation of care. The refraction fee is $40 and may not be covered by your insurance company (including Medicare).

Initial ____________

DILATING EYE DROP INFORMATION:

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of the eye. Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for the ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it is best if you make arrangements not to drive yourself. Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with medical attention. I authorize TEA to administer dilating eye drops which are necessary to diagnose my condition.

Initial ____________

CONSENT TO MEDICAL TREATMENT & PROCEDURES

The undersigned consents to medical treatment, as may be deemed necessary or advisable to the judgment of the Tomoka Eye physician; which may include but is not limited to laboratory procedures, special testing, examination, photography, medical treatment or procedures, or other services rendered to the patient under the general and special instructions of the patient's physician.

Initial ____________