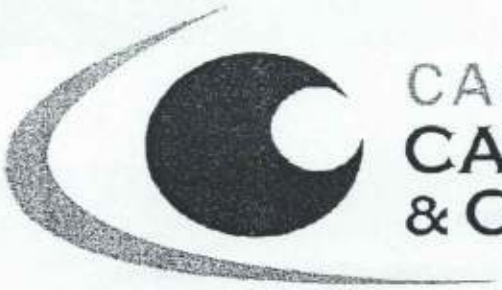

CAPE FEAR
CATARACT
& CORNEA

1915 S. 17th Street, Suite 101, Wilmington, NC 28401

14 Doctor's Circle, Suite 5, Supply, NC 28462

Phone: 910-769-4590

Patient Information Date: / /

Last Name	First	MI	Date of Birth / /	Age	Sex □ Male □ Female
Street Address	City	State	Zip	Social Security Number	
Home Phone	Work Phone	Cell Phone	Email Address		

Marital Status
□ Single □ Married □ Separated □ Divorced □ Widowed

Ethnicity □ NOT Hispanic or Latino □ Hispanic or Latino □ Decline to Answer	Preferred Language □ English □ Other:_____

Race
□ White/ Caucasian □ Black/ African American □ Asian □ Other □ Decline to Answer

Spouse's Name	Spouse's Date of Birth / /	Spouse's Social Security Number
Emergency Contact Name	Relationship	Emergency Contact Number
Optometrist/ Ophthalmologist	Primary Care Physician	
Pharmacy Name	Pharmacy Address	Pharmacy Phone

INDIVIDUAL RESPONSIBLE FOR PAYMENT
PLEASE FILL OUT IF DIFFERENT THAN PATIENT

Last Name	First	MI	Date of Birth / /	Relationship
Street Address	City	State	Zip	
Home Phone	Work Phone	Cell Phone	Social Security Number	

(Continued on back)

Patient Acknowledgement Regarding Precautions Following Dilation

It may be necessary to dilate your eyes during your eye examination or treatment. Dilation results in sensitivity to light and an inability to see well at close range or distance for a few hours. Patients should wear sunglasses, be cautious walking and going up or down stairs. We recommend not driving or operating dangerous machinery immediately after dilation. We recommend that someone drive you home or that you wait until your eyes return to normal so that you can drive safely.

Refraction Service and Fee

A refraction (CPT 92015) is necessary to determine the performance of the visual system and is an essential part of the medical eye exam. Although a refraction is also used to determine the need for corrective eyeglasses, this practice performs refractions as a necessary part of the medical exam. A refraction is also necessary to evaluate a patient for surgery. Unfortunately, some insurance plans (including Medicare) DO NOT cover the cost of refractions. In these cases, the patient will be responsible for the refraction fee.

A topography (CPT 92025) is also an important part of your evaluation and provides valuable information to your surgeon. This test may not be covered by your insurance and you will be responsibility if not covered.

A REFRACTION IS NOT A COVERED SERVICE BY MEDICARE AND MOST INSURANCE PLANS.

This practice will collect the refraction fee at the time of service if we know that your plan will not cover the cost. If we are unsure if your plan will cover the fee, we will submit the charge to your insurance as a courtesy, HOWEVER you are ultimately responsible for the payment.

All copayments are due at the time of service and will be collected at check-in. Payment toward your deductible will also be due at the time of service.

Insurance and Non-Covered Services

As our patient, we want to provide you with the best care possible. There may be certain services we feel are necessary for the maintenance of good health that will not be covered by your insurance company. ***You will be expected to pay for any non-covered services.*** Please be assured we will order only those tests and perform only those services that are necessary for your treatment and care. We may not always know for certain how YOUR insurance company will process YOUR claim.

Please note that verifying your insurance coverage is YOUR responsibility. Please provide copies of your current insurance cards to this office at each visit. If you have a question about your coverage, or how your claim was processed, please contact your insurance provider directly. If we file a claim and it is denied because our services are not covered under your insurance plan, you will be billed directly for all cost associated with your visit.

I have read and understand the above information. I accept full financial responsibility for the cost of any non-covered services, deductibles, co-insurance and copayments and I understand what services I will be required to pay at the time of service. I also understand that an additional fee of $30.00 will be charged to any account that is turned over to the collection agency for non-payment of services.

I authorize the release of any information concerning my healthcare, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me, directly to Cape Fear Cataract and Cornea, P.A.

_____

Patient Name Printed

_____ _____

Patient Signature / Authorized Representative Date

CAPE FEAR CATARACT & CORNEA

Patient History Questionnaire

Name:_____ Date:_____

PAST MEDICAL HISTORY: Do **you** have any of the following conditions?

	yes	no		yes	no		yes	no
High Blood Pressure			Arthritis			Cancer		
Diabetes			Anemia			Seizures		
Heart Disease			Thyroid Disease			Kidney Disease		
Asthma			Stroke			Migraines		

ANY OTHER MEDICAL PROBLEMS: _____

_____

_____

PAST SURGICAL HISTORY: Have you had any surgeries?

Ocular Surgeries:	Yes	No	Right	Left
Cataract surgery				
Retinal detachment				
LASIK				
Glaucoma surgery				
□ No ocular surgeries				

Other Surgeries:_____

_____

_____

_____

_____

□ No other surgeries

MEDICATIONS: □ Not using any medications

1._____ 7._____ 13._____

2._____ 8._____ 14._____

3._____ 9._____ 15._____

4._____ 10._____ 16._____

5._____ 11._____ 17._____

6._____ 12._____ 18._____

EYE MEDICATIONS: _____

DRUG ALLERGIES: _____

_____

Latex: □ Yes □ No □ No known drug allergies

FAMILY HISTORY: Does any of your **family** have a history of the following conditions?

	Mother	Father	Brother	Sister		Mother	Father	Brother	Sister
Diabetes					Glaucoma				
High Blood Pressure					Macular Degeneration				
Heart Disease					Retinal Problems				
Cancer					Fuchs' Dystrophy				

SOCIAL HISTORY: Do you smoke? □ Yes □ No □ Never Smoker □ Former Smoker

Do you drink alcohol? □ Yes □ No Do you drive? □ Yes □ No

Hobbies: _____