

**Siepsler Laser Eye Care**  
**PATIENT REGISTRATION FORM**

Date: \_\_\_\_\_

**PATIENT INFORMATION**

First Name \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Gender:  Male  Female Marital Status: \_\_\_\_\_

SSN: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer Phone Number: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

How did you find us? \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

**INSURANCE INFORMATION**

Primary Insurance Company and Policy number: \_\_\_\_\_

Secondary Insurance Company and Policy number: \_\_\_\_\_

Who is responsible for the policy (primary holder)? \_\_\_\_\_

Date of Birth for Primary holder: \_\_\_\_\_

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Surgical Eye Care, LTD, t/a Siepsler Laser Eye Care or insurance company to release any information required to process my claims.

**Patient/Guardian signature**

**Date**

# Medical History Questionnaire

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Please answer the following questions to the best of your ability. Give dates, a brief description and which eye was involved to any yes answer.

Reason for visit: \_\_\_\_\_

## Ocular History

Have you ever had any eye disease, surgery or injury? No  Yes

If yes, please describe including dates and the name of the doctor who treated you.

Date	Doctor	Description
_____	_____	_____
_____	_____	_____

Have you ever worn glasses or contact lenses? No  Yes

How old is your prescription? \_\_\_\_\_

Have you ever been told you have amblyopia or "lazy eye"? No  Yes

## Medical History

Have you ever had major surgery or been hospitalized for any reason? No  Yes

If yes, please describe: \_\_\_\_\_

Have you ever had any complications from anesthesia? No  Yes

If yes, please describe: \_\_\_\_\_

## Family History:

Blindness	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Diabetes	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Cataract	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Heart Attacks	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Glaucoma	No <input type="checkbox"/>	Yes <input type="checkbox"/>	High Blood Pressure	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Macular Degeneration	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Thyroid Disease	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Strabismus (Lazy Eye)	No <input type="checkbox"/>	Yes <input type="checkbox"/>			

If yes to any of the above, please explain relationship to patient: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

*The above medical information that I proved is true and accurate to the best of my knowledge.*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## History

Does your vision make it difficult for you to?

Read?	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>
Write?	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>
Drive?	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>
Cook?	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>
Sew?	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>
Watch TV?	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>
Work?	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>

Do you:

Smoke?	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>
Chew tobacco?	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>
Drink alcohol?	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>
Use illegal drugs?	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>

Do you have any **DRUG** or **ENVIRONMENTAL** allergies? No  Yes   
 If yes, please list the name of the drug or describe allergy (dust, pollen, etc.) \_\_\_\_\_

What kind of reactions have you experienced? \_\_\_\_\_

## Medications

Please list **all medication(s)** including eye drops, which you are currently taking. List the amount or strength of the medication(s) and how frequently you take the medication(s).

Name of Medication	Amount Taken	Times Taken per Day	Which Eye?

## Review of Systems

Do you have any problem in the following areas? If yes, please explain.

Skin	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	_____
Head (Headaches)	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	_____
Ears, Nose, Throat and Mouth	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	_____
Lungs/Breathing (TB)	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	_____
Heart (High Blood Pressure)	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	_____
Stomach/Intestines	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	_____
Genitals, Kidney, Bladder	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	_____
Bones, Joints, Muscles	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	_____
Neurologic System	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	_____
Lymph Nodes/Swelling	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	_____
Blood (HIV Positive, Hepatitis)	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	_____
Allergic, Immunologic	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	_____
Endocrine (Diabetes, Thyroid)	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	_____
Psychiatric	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	_____
Other	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	_____

*The above medical information that I proved is true and accurate to the best of my knowledge.*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**General Questions Regarding Lasik Procedure:**

How long have you been thinking about having the procedure done?

Less than 2 months \_\_\_\_\_ 2-6 months \_\_\_\_\_ 6-12 month \_\_\_\_\_ more than 1yr \_\_\_\_\_

How did you hear about Dr. Siepser?

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What are the top three factors driving you to have Laser Vision Correction (LASIK)?

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What would be one deterring factor that would hold you back from getting the LASIK procedure done?

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What is your primary goal/expectation for have Laser Vision Correction?

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Do you have any specific questions about Laser Vision Correction?

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Have you ever been told by another physician that you were not a candidate for Laser Vision Correction?

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## **SIEPSEY LASER EYECARE FINANCIAL POLICY**

Thank you for choosing Siepser Laser EyeCare. We are committed to providing you with excellent service in every area including billing and insurance claims filing. Please read and sign our Financial Policy.

Our practice participates in many Medical and Vision insurance plans. If your plan does not cover services provided by our physicians, payment in full is expected at the time of your visit. We accept cash, checks, VISA, MasterCard, Discover and American Express.

**Please be sure to provide us with your most current insurance card(s) at each visit.** We cannot properly file your insurance claim if we do not have accurate insurance information in your account. If you do not have your insurance card with you at the time of service we will be happy to see you but payment in full will be due at the time of service. You must bring your insurance card to us in order for the claim to be filed. Once payment has been received from your insurance company, we will gladly refund the patient payment less any applicable co-pays or deductible. *We must emphasize that your insurance coverage is a contract between you and your insurance company. We are a specialty practice. We realize temporary financial difficulty may affect the timely payment of your account. It is your responsibility to contact us promptly for assistance in the management of your account. Remember we are here to help.*

Currently all of the insurance plans we are contracted with require that we provide the patient's full name, date of birth, social security number and complete home address. If you feel uncomfortable providing us with that information, we will provide you with a bill so you can file your own claim with your insurance plan. If you choose to file the claim yourself, payment in full will be due at the time of service.

**Office Visits:** Eye Examinations have two portions, the eye exam and the refraction. The refraction is the measurement taken to determine if there is a need for glasses and if so, your glasses prescription. Refractions may be done for routine eye exams or medical exams. **Most insurance plans, including Medicare do not pay for refractions. You will be asked to pay for the refraction at the time of your visit. This \$47.00 fee is additional to any co-pay or deductible. If you currently wear, or wish to start wearing contacts, there is separate charge for the contact lens fitting which must be paid at the time of service.** Many insurance plans require a referral/authorization for specialist office visits. You will need to obtain this referral/authorization from your primary care physician **prior** to being seen in our office.

Initials \_\_\_\_\_

**NON-COVERED SERVICES/TESTING POLICY:** Under your health plan, you are financially responsible for copayments, co-insurance and deductibles for covered services, as well as those services that exceed benefit limits. You are also financially responsible for all non-covered services as defined by your health plan contract. For example, this may include services such as routine eye care, contact lenses, refractions, topography tests, schrimmer tests,

upgraded IOL implants, cell counts, orbscans and/or wave scans. Your acknowledgement below indicates that you have been advised of this information and that you agree to pay for the services if they are needed to treat and or diagnosis a medical condition for which you are being followed and/or treated.

Initials \_\_\_\_\_

**Surgery:** If you are having surgery we will assist in getting pre-certification or prior approval for your procedure. Please keep in mind that most insurance plans have deductibles, copayments, or both, associated with surgery, and you will be responsible for payment of these fees at the time of service. We suggest that your review your insurance plan prior to visiting our office, so you will be familiar with your insurance plan guidelines and requirements. Please be prepared to pay patient responsibility at the time of service.

Initials \_\_\_\_\_

**Billing and Credit:** Statements will be mailed monthly and are due for payment with 30 days. Monthly statements will follow until the account is paid in full. If you have any questions, please feel free to discuss them with our Insurance/Billing Department by call (610) 265-2020 ext 114 or (610) 265-2020 ext.108. If you have not paid your bill, or have not set up payment within 90 days, we will ask for assistance from our collection agency.

Initials \_\_\_\_\_

**PROFESSIONAL COURTESY POLICY AND CODE CHANGE REQUESTS:** We greatly value our privilege to provide medical care to all of our patients. In accord with state and federal regulations, it is potentially unlawful to accept “insurance only”, to waive copays, and/or to alter codes that accurately depict medical services rendered. For these reasons, the practice of making “professional courtesy” adjustments is strictly prohibited at all Siepser Laser EyeCare Practices, as is the practice to alter codes that accurately depict the services rendered.

Initials \_\_\_\_\_

**CONSENT FOR TREATMENT**

The undersigned Patient/Guardian has received a copy of our financial policy and hereby authorizes the physicians of Siepser Laser EyeCare, and the employees’, to perform any treatment or procedures they may deem necessary for the Patient’s treatment.

\_\_\_\_\_/\_\_\_\_\_  
Signature of Patient/Guardian Date

I hereby authorize the staff of Siepser Laser EyeCare to release information to insurance carriers, appropriate physicians and/or Workers’ Compensation departments, as required, concerning my illness and treatments and authorize all payments made to Siepser Laser EyeCare. I understand that if I did not get prior authorization as required by my insurance, that I will assume all financial responsibility for such charges associated with my visit.

- I am aware of Siepser Laser Eye Care Office Financial Policy.
- I have been offered or have received a copy of Siepser Laser Eye Care’s “Notice of Privacy Practice.”

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Signature of Patient and/or Guardian Date

Steven B. Siepser, M.D., F.A.C.S.  
Daniel Merrick Kane, M.D.  
Christine Chung, M.D.  
Eris P. Jordan, OD

## NOTICE OF PRIVACY PRACTICES

By Signing below, I acknowledge that I have read and received Surgical Eye Care, LTD, t/a Siepser Laser Eye Care's **Notice of Privacy Practices** and authorize Surgical Eye Care, LTD, t/a Siepser Laser Eye Care to use, access and disclose my health information in the manner described in the notice.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_