cteyecare
healthy eyes & kind hearts
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FAX 203.426.5113
14 Church Hill Rd
Newtown, CT 06470

REGISTRATION HISTORY

Patient's Name_____Date of Birth_____

Street Address_____ SSN (last four) XXX-XX- _____

City / State / Zip_____

Cell Phone _____ Home Phone _____

Preferred Local Pharmacy_____ Address/Location_____

Occupation_____Employer _____

Email_____

May we have your permission to communicate via email regarding prescriptions/appointments? ○ Y ○ N

Do you wear contact lenses? ⊙ Y ○ N Are you interested in purchasing contacts? ○ Y ⊙ N Do you have Diabetes? ○ Y ⊙ N

*****Please note that a contact lens evaluation is a separate exam and will be an additional charge on top of any co-pays*****

Who can we thank you for you referring you?_____

How did you hear about us? ☐ Insurance Comp ☐ Google/Internet Search ☐ Facebook Other_____

Please initial on the lines indicating that you have seen, read and understand this information given to you today:

ADVANCE BENEFICIARY NOTICE & SIGNATURE ON FILE

I authorize the use of this form on all my insurance submissions. I authorize release of information to all my insurance companies or their representatives. I permit a copy of this authorization to be used in place of the original. I authorize payment direct to my doctor.

I understand that any balance or service not covered by insurance will be my responsibility. Payment for non-covered services is due at time of service. Overdue balances past 6 months (180 days) will be forwarded to collection with a processing fee (20% of balance amount). I will be responsible for all returned check fees ($25).

ADVANCE BENEFICIARY NOTICE & SIGNATURE ON FILE: _____ I have seen, read and understand the policy above.

DILATED FUNDUS EXAM & OPTOS + OCT RETINAL IMAGING POLICY (located on the clipboard)

_____ I have seen, read and understand the policies

YOU MUST CHOOSE: ☑ Do ***NOT dilate***, I ***PREFER*** retinal imaging for an **additional $49 charge.**

☐ I would like to be **dilated** today **(if you have diabetes, you *MUST* be dilated)**

PRIVACY POLICY: _____ I have seen, read and understand the policy **(located on the clipboard)**.

PATIENT OR GUARDIAN SIGNATURE (self or parent): _____ DATE _____

INSURANCE POLICY HOLDER (self, spouse, or parent):

NAME _____ DATE OF BIRTH _____LAST 4 SSN: _____