

Patient Registration Form

PLEASE FILL OUT PAGES 1-4 FOR THE PAGES THAT APPLY TO YOUR VISIT

Doctor will not perform exam on child under 18 years of age without a written or verbal consent of legal guardian.

Patient Information

Today's Date / / Email
Patient's Name (First, Middle, Last)
Nickname (if differs from above) Age Birth Date / /
Street Address
City- State- Zip code-
Marital Status ()Single ()Married ()Widowed ()Other
Social Security Number Gender ()Male ()Female
Phone Number Home Cell Work

Emergency Contact/Legal Guardian (Name) (Ph#)
Relationship to Patient
Referred by:

Employment Information

Employer Occupation

Primary Insurance

Vision Company ID #
Primary Insured Person (Name/DOB/SSN)
Medical Company ID #
Primary Insured Person (Name/DOB/SSN)

Secondary Insurance

Vision Company ID #
Primary Insured Person (Name/DOB/SSN)
Medical Company ID #
Primary Insured Person (Name/DOB/SSN)

HIPPA

The HIPPA policy can be viewed at the front desk or a copy will be given upon request. Please choose ONE of the following:

- () I have read the HIPPA policy and agree with the statement.
() I have requested a copy of the HIPPA policy and have been given one, but have not yet read it.
() I refuse to read and/or refused a copy of the HIPPA policy and decline treatment.

I understand the HIPPA rights and agree with the guidelines. (Initials)

Cancelation/No Show Policy

Your appointment time is reserved especially for you. Please call or use the online scheduler to cancel your appointment at least 24 hours prior to your scheduled appointment if you will be unable to keep your appointment. This allows Dr. Trapeni to offer that time to another patient. If a patient forgets or fails to show up for their appointment, there will be a \$35.00 fee charged to your account. The same applies to appointments canceled with less than 24 hours' notice. Patients who schedule and fail to keep two appointments in the span of one year will be dismissed from the practice. (Initials)

PLEASE TURN OVER THIS PAGE FOR THE MEDICAL PORTION (Page 1 of 4)

Primary Care Physician/Last Examinations

Doctor Name _____ Phone _____
Location () Smyrna () Murfreesboro () Nashville () Other _____
Last Physical ____/____/____

Last Eye Exam ____/____/____ Dr. _____
Do you wear?
Glasses _____
Contacts _____ Brand _____ Sleep in contacts? _____ Replace contacts every? _____

Medications

Please list ALL medications you currently are taking, if you have a list we will be happy to make a copy.

Drug Allergy _____

System Review/Chief Complaints Have you had in the past YEAR?

* Eyes			* Ear/Nose/Throat			* Respiratory		
Burning	Y	N	Hearing Loss	Y	N	Asthma	Y	N
Redness	Y	N	Bad breath	Y	N	Smoker	Y	N
Dry	Y	N						
Itchy	Y	N	* Cardiovascular			* Genitourinary		
Distance blur	Y	N	Heart Trouble	Y	N	Pregnant	Y	N
Near blur	Y	N	High Blood Pres.	Y	N	Lactating	Y	N
Double vision	Y	N	High Cholesterol	Y	N			
Vision Loss	Y	N	Heart Attack	Y	N	* Allergic		
Flashes of light	Y	N				Seasonal Allergy	Y	N
Floaters/Spots	Y	N	* Musculoskeletal			* Endocrine		
Turned/Lazy Eye	Y	N	Joint Pain/Stiff	Y	N	Hormone Cond.	Y	N
Twitching Eyelid	Y	N	Back/Neck Pain	Y	N	Thyroid Cond.	Y	N
Headaches	Y	N	Lupus	Y	N	Diabetes	Y	N
Glaucoma	Y	N	Rheum. Arthritis	Y	N	HIV or AIDS	Y	N
Ret. Pigmentosa	Y	N	M.S.	Y	N	Adrenal Cond.	Y	N
Ret. Detachment	Y	N	Fibromyalgia	Y	N			
Cataracts	Y	N						
Macular Degener.	Y	N	* Psychiatric					
			Memory Loss	Y	N			
			Depression	Y	N			
* Eye Surgery			Insomnia	Y	N			
PRK	Y	N	Anxiety	Y	N			
Lasik	Y	N						
Eye muscle	Y	N						
Cataract	Y	N						
Glaucoma	Y	N						
Retinal	Y	N						

Family Medical History

() HBP () Diabetes () Multiple Sclerosis () Glaucoma () Retinitis Pigmentosa () Cataracts
() Macular Degeneration () Retinal Detachment

MEDICARE PATIENTS- Medicare does not cover refraction.

Any balance after insurance will be the responsibility of the patient or guardian. I authorize Dr. Trapeni to contact me for future appointments by phone, mail or email. Any fee's acquired during collections are the patient's responsibility.

Patient/Guardian Signature: _____

If you wear contacts: Please review policy and sign/date.

Contact Lens Fees: What You Should Know: Contact lenses are medical devices that can cause serious consequences, such as infections, inflammation, permanent damage and loss of vision if not fit and taken care of properly. Examining a contact lens patient takes additional time and expertise. For that reason, there are separate, additional charges for contacts lens examinations that patients without contact lenses do not pay.

Contact Lens Fitting: In addition to your regular eye examination, there is a fitting fee associated with trying new contacts lenses. There are thousands of types of lenses, and Dr. Trapeni will need to take special measurements and determine which lens type will work for you. Your initial design fee will cover ocular surface evaluation, diagnostic lenses, lab or shipping fees, fitting analysis and any follow visits necessary to obtain a satisfactory fit. If you have never worn contacts before, your fitting will also include a class in which new wearers will learn to insert and remove contacts, cleaning and care techniques. This fee may also depend on what kind of contacts you wear; for example, bifocal or astigmatism contact lenses are more difficult to fit and fine tune and take longer to adjust to than standard lenses. The fit is finalized you and the doctor agree the fit has been successful, or if either of you determines that contact lenses are not an acceptable option for your eyes. Your initial fitting fee includes 90 days of follow-up; any additional visits required to finalize your fit are subject to a per-visit fee. Once finalized, any future lens changes in brand or type will be considered a refit and will be subject to new fees.

Annual Contact Lens Evaluation: Once finalized, per Tennessee state regulations, your contact lens prescription will be valid for up to 1 year. This means you can purchase enough lenses to last for 12 months and no more. After 12 months, the prescription expires. If you want to continue to wear contact lenses, you must return for a comprehension eye examination and contact lens evaluation. The doctor will verify that your eyes are responding well to contact lens wear, check the ocular surface for any damage and make sure the lenses are still fitting properly and are the correct prescription for your eyes. The cost for this evaluation will depend on the type of lenses you wear. This type of examination is necessary if you wish to continue wearing contact lenses. The doctor will not renew expired prescriptions without first making sure that your eyes are healthy enough to continue to wear lenses. To avoid any inconvenience, make sure your annual examination is scheduled on time so that you do not run out of lenses before you are seen. If you wear contact lenses, this examination must be done annually, even if your insurance only allows for a 2-year examination interval. If for some reason, you require additional time or visits because there has been a change in the type of lenses you wear, there may be additional refitting fees. These cover any extra trials, examination time and follow-up appointments that may be necessary to finalize a refit into another type of contact lens.

Custom Contact Lens Fitting Policy: You have been dispensed a pair of custom-made contact lenses. These lenses were provided by an outside lab and come with a limited return policy. You are allowed adjusted remakes (new lenses only) within 90 day of the order date. All previous lenses must be returned before we can dispense each new remake. If you break a lens during the fitting period, we will replace it free of charge: if your remakes remaining and if the broken pieces are returned. If no remakes remain or the 60 day trial period elapsed, you will be responsible for the cost of replacing broken lenses. Some materials have warranties that allow for breakage but THIS IS NOT GUARANTEED. In any case, you must return the broken pieces of the lens to get the warranty replacement. Lost lenses are not covered under any warranty or remake and you will be responsible for the cost of replacing your lens. Available remakes will not replace lost lenses. If, for any reason, you or the doctor decide to discontinue the lens fitting process or choose not to wear the contact lenses, any contact lenses given must be returned within 60 days of the initial dispensing date. If you return the lenses in the allotted time, the cost of the lenses minus and shipping costs will be refunded. The contact lens fitting fee that encompasses any office visits and training classes during the fitting in nonrefundable.

Contact Lens Supply: After you have been fit with an appropriate lens, you will have the option of buying a supply of lenses that will last up to 1 full year. You will have to replace your lenses as directed, which can range anywhere from daily, bi-weekly, monthly- quarterly or yearly. Buying a year's supply of contact lenses at one time is beneficial because discounts or rebates may be available, and because you will have the convenience of having new lenses on hand when you need to replace them, so that you are not tempted to wear dirty, old or damaged lenses.

DR. TRAPENI DOES NOT REFUND OR FURTHER DICOUNT ANY PROFESSIONAL SERVICES THAT ARE RENDERED.

By signing below you have agreed to the above policy. If you have any questions, please do not hesitate to contact us at any time.

Signature: _____

Date: _____

If the appointment is for a child 12 years old or under, Please fill out below form.

Children's Visual Efficiency Checklist

Please estimate how often your child exhibits the behaviors on this list.

Circle 1 if this NEVER happens to 6 if this ALWAYS happens.

- | | | | | | | |
|---|---|---|---|---|---|---|
| 1. Complains of headaches, sore eyes or blurred vision. | 1 | 2 | 3 | 4 | 5 | 6 |
| 2. Comprehension reduces as reading continues. | 1 | 2 | 3 | 4 | 5 | 6 |
| 3. Squints or blinks excessively at desk tasks or reading. | 1 | 2 | 3 | 4 | 5 | 6 |
| 4. Holds book too close to face when reading. | 1 | 2 | 3 | 4 | 5 | 6 |
| 5. Loses place during reading. | 1 | 2 | 3 | 4 | 5 | 6 |
| 6. Insert or skip small words when reading. | 1 | 2 | 3 | 4 | 5 | 6 |
| 7. Uses finger to keep his/her place. | 1 | 2 | 3 | 4 | 5 | 6 |
| 8. Confuses minor differences in words when reads. | 1 | 2 | 3 | 4 | 5 | 6 |
| 9. Reverses letters/words in writing. | 1 | 2 | 3 | 4 | 5 | 6 |
| 10. Writes crooked, poorly spaced or does not stay in the lines when writing. | 1 | 2 | 3 | 4 | 5 | 6 |
| 11. Fails to complete board work on time. | 1 | 2 | 3 | 4 | 5 | 6 |