



Dear Patient,

Welcome to Triad Ophthalmic Physicians, PLLC. Your visit with us will last approximately 2 hours. Your time is very valuable to us, and we understand that our visits are long. We make every effort to complete as many tests or procedures that you may require for your condition so that we may reduce the need for additional visits.

Your appointment takes place at 150 Kimel Park Drive Suite 200 Winston Salem, NC 27103

Your eyes will be fully dilated to ensure a thorough exam.

Please bring the following to each visit:

- Your Drivers' License or Photo ID
- Your current health insurance cards
- Your prescription glasses
- A current list of your medications
- Sunglasses to wear after your appointment
- Your copay is required at the time of visit

Please review and fill out the attached forms, and please do not hesitate to ask any questions. We also need to know who your primary physician is, or any other doctors that may need reports.

Please note that we are a private practice and we do not have access to your medical information from any doctor.

We have a 24-hour cancellation policy. If you are unable to make your appointment, please contact us at 336-760-2240.

We strive to make your visit to our office as enjoyable as possible. Please let us know if there is anything we can do to make your visit more pleasant.

Thank you so much!

The Doctors and Staff of Triad Ophthalmic Physicians, PLLC



## PATIENT REGISTRATION

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

Birthdate: \_\_\_\_\_ Sex: M/F Marital Status: \_\_\_\_\_ Race: \_\_\_\_\_

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

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

Home Phone: \_\_\_\_\_ Cellphone: \_\_\_\_\_

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

SSN: \_\_\_\_\_ E-MAIL: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_

If insurance is through spouse/parent please provide the following information:

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Phone: \_\_\_\_\_ Send Correspondence: YES/NO

I certify that I (or my dependent) have insurance coverage as stated above and agree to have insurance payments made directly to Triad Ophthalmic Physicians, PLLC to be applied to my account for services rendered. I understand that I am financially responsible for all charges incurred in the event that my insurance denies payment. I understand and agree that Triad Ophthalmic Physicians, PLLC may release information if necessary for my treatment to process insurance claims. I am aware there may be additional collection and/or attorney's fees if my account is referred for collection.

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## MEDICAL HISTORY

Date \_\_\_\_\_

Name \_\_\_\_\_ Date of **last eye exam** \_\_\_\_\_

What **medications** and **supplements** (Rx & OTC) do you currently take?

Do you have any **allergies** to medications?     YES     NO    If yes, please list:

What **major illnesses** or **injuries** have you had?

Have you had any **EYE surgeries**?     YES     NO    If yes, please list:

Do you *currently* have any problems in the following areas?     YES     No

If "YES", Please provide explanation.

Eyes	
Ears, Nose, Throat	
Cardiovascular	
Respiratory	
Gastrointestinal	
Genital, Kidney, Bladder	
Muscles/Joints, Bones	
Skin	
Neurological	
Psychiatric	
Endocrine	
Blood, Lymph	
Autoimmune Disease	

Complete on back →

**FAMILY**

Any family medical history of eye problems (parents, grandparents)? \_\_\_\_YES \_\_\_\_NO

If YES, describe: (example Glaucoma, Macular Degeneration, Skin cancer)

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**SOCIAL**

What is your occupation? \_\_\_\_\_

Do you drive? \_\_\_\_YES \_\_\_\_NO

Do you have visual difficulty when driving? \_\_\_\_YES \_\_\_\_NO

Do you have problems with night vision? \_\_\_\_YES \_\_\_\_NO

Do you have problems with glare? \_\_\_\_YES \_\_\_\_NO

Do you drink alcohol? \_\_\_\_YES \_\_\_\_NO If yes, how often? \_\_\_\_\_

Do you smoke/use tobacco products? \_\_\_\_YES \_\_\_\_NO If yes, how often? \_\_\_\_\_

Physician's Signature: \_\_\_\_\_



# Attention

It is the responsibility of the patient to know your insurance and understand your coverage. If your insurance requires a referral from your primary care provider and you do not get a referral, then you are responsible for the charges for that office visit. Also, insurance rarely pays for 100% of your healthcare needs and at times there may be remaining balances on your account due to deductibles, co-pays, or non-covered services. These are also the responsibility of the patient.

All telephone numbers provided by you may be subject to receiving telephone calls from an automated dialer using a pre-recorded, artificial voice message or live operator call. You give your express consent to receive such phone calls, including any calls made to your provided cellular telephone number.

I understand and agree to the above statements:

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



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

May we leave detailed messages with medical information on the number that you provided to us?

\_\_\_\_\_ Yes      \_\_\_\_\_ No

Do you have a particular person or family member that you authorize to receive and discuss information regarding your personal health information (general information, surgical, and billing)

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Phone: \_\_\_\_\_ Alternate Number: \_\_\_\_\_

Is this person your Power of Attorney?    \_\_\_\_\_ Yes      \_\_\_\_\_ No

I hereby authorize Triad Ophthalmic Physicians to obtain or release any and all pertinent information regarding my medical care, as needed, to assist in my ongoing treatment to or from other health care providers, laboratories, radiology facilities, or other institutions. **This authorization remains in effect until revoked.**

I have read the aforementioned information and provide my consent regarding any and all the issues as stated above

I have reviewed the Notice of HIPAA Privacy Policy. A copy of this policy will be provided to me upon request.

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

Witnessed By: \_\_\_\_\_

