little eyes
Pediatric Eye Care & Adult Strabismus
3801 W. 15th St., Suite A-110
Plano, TX 75075

Becky Luu, OD, FAAO
Eurika Rajbanshi, OD

Patient Registration Form

Patient Information (*for both adult and pediatric patients*)

Patient Name: _____ ☐ Male ☐ Female

Street: _____ City: _____ State: _____ Zip:_____

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ Social Security # _____

Email Address: _____

Referring Physician: _____ Telephone # _____

Primary Physician: _____ Telephone # _____

Patient's or Parent/Guardian's Employer: _____

Address: _____

Work Phone # _____

Emergency Contact Name:_____ **Phone #** _____

Pediatric Patient Family Information (not required for adult patients)

Family status: Patient is living with: ☐ Parents ☐ Relative ☐ Guardian ☐ Foster parents
Patients parents are: ☐ Married ☐ Separated ☐ Divorced

Full Name of Father (or Guardian):

_____

Social Security # _____
Date of Birth: _____
Home Address: _____
_____
_____
Telephone # _____
E-mail Address: _____

Full Name of Mother (or Guardian):

_____

Social Security # _____
Date of Birth: _____
Home Address: _____
_____
_____
Telephone # _____
E-mail Address: _____

Reason for visit

_____

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Patient History
(1 of 2)

Patient's History of Eye Problems

Family History: Is the patient natural _____ adopted _____

Yes	No		
☐	☐	Glasses: How old is the current pair?	_____
☐	☐	Contacts: How old is the current pair?	_____
☐	☐	Prisms: How long?	_____

Yes	No	Past Ocular History	Age	Yes	No	Past Ocular History	Age
☐	☐	Eye exam by specialist	_____	☐	☐	Eye Injury	_____
☐	☐	Patching	_____	☐	☐	Stye	_____
☐	☐	Eye exercises	_____	☐	☐	Recurring "pink eye"	_____
☐	☐	Eye muscle surgery	_____	☐	☐	Cataract	_____
☐	☐	Other eye surgery	_____	☐	☐	Glaucoma	_____
☐	☐	Diabetic eye disease	_____				

Diagnosed eye diseases not mentioned above

_____

_____

Eye Conditions in Other Family Members

Yes	No		Which relative? (check one)
☐	☐	Glasses before age 6	☐Father ☐Mother ☐Sister ☐Brother ☐Other
☐	☐	Amblyopia ("lazy eye")	☐Father ☐Mother ☐Sister ☐Brother ☐Other
☐	☐	Patching treatment	☐Father ☐Mother ☐Sister ☐Brother ☐Other
☐	☐	Strabismus (crossed or wandering eye)	☐Father ☐Mother ☐Sister ☐Brother ☐Other
☐	☐	Eye muscle surgery	☐Father ☐Mother ☐Sister ☐Brother ☐Other
☐	☐	Cataracts	☐Father ☐Mother ☐Sister ☐Brother ☐Other
☐	☐	Glaucoma	☐Father ☐Mother ☐Sister ☐Brother ☐Other

Other Serious eye disease (describe)

_____

_____

Brothers and Sisters (Not required for Adult patients)

Full Name	Age	Is he/she a patient of Dr. Luu's/ Dr. Rajbanshi's?
_____	_____	☐Yes ☐No
_____	_____	☐Yes ☐No
_____	_____	☐Yes ☐No
_____	_____	☐Yes ☐No

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Patient History
(2 of 2)

Patient's Medical History

Yes	No	Condition	Yes	No	Condition
☐	☐	Frequent ear infections	☐	☐	Diabetes
☐	☐	Sinus Disease	☐	☐	Anemia
☐	☐	Heart Disease	☐	☐	Kidney Disease
☐	☐	High blood pressure	☐	☐	Neurological Disease
☐	☐	Asthma	☐	☐	Seizures or stroke
☐	☐	Allergies	☐	☐	Depression
☐	☐	Arthritis	☐	☐	Cancer
☐	☐	Thyroid problem	☐	☐	Other illness not mentioned (describe below)
☐	☐	Previous surgery or hospitalization			

_____

Patient's Medication

Eye drop and frequency: _____Why is this medication being used?_____

Medication and dosage: _____Why is this medication being used?_____

List any known allergies to medication : _____

Patient's Birth History *(not required for adult patients)*

Birth Weight _____ lb _____ oz

Yes	No	Condition
☐	☐	Problems in pregnancy. Describe: _____
☐	☐	Problems in delivery. Describe: _____
☐	☐	Forceps delivery
☐	☐	Cesarean section
☐	☐	Delivered early
☐	☐	Delivered late
☐	☐	Baby kept in hospital due to illness. Why and how long? _____
☐	☐	Delay in sitting, walking, talking or development. Describe: _____
☐	☐	Any outstanding school difficulties. Describe: _____

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Insurance/ Payment

Insurance Information

PRIMARY INSURANCE

Insurance Name: _____
Policy Number: _____
Group Number: _____
Subscriber Name: _____
Subscriber Address: _____
_____
Subscriber SS# _____ Birth Date _____
Relationship to Patient: _____

SECONDARY INSURANCE

Insurance Name: _____
Policy Number: _____
Group Number: _____
Subscriber Name: _____
Subscriber Address: _____
_____
Subscriber SS# _____ Birth Date _____
Relationship to Patient: _____

Insurance Authorization and Assignment

I hereby authorize my insurance carrier(s), including Medicare to issue payment directly to Becky Luu, OD, FAAO/ Eurika Rajbanshi, OD, for medical services rendered to myself and/or my dependent regardless of my insurance benefits. I understand that I am responsible for any amount not covered by insurance.

I hereby authorize Becky Luu, OD, FAAO/ Eurika Rajbanshi, OD, to (1) release any information to insurance carrier regarding my illness and treatment, (2) to process claims generated in the course of examination, or treatment, and (3) to allow a photocopy of my signature to be used to process insurance claims.

_____ _____
Signature of Patient/ Legal Guardian Date

Authorization

I hereby give my consent to the physician and other clinical personnel of Becky Luu, OD, FAAO/ Eurika Rajbanshi, OD, for my evaluation and treatment on an ongoing basis.

I understand that I have the right to revoke this consent in writing, at any time, except when the physicians or other clinical personnel have already taken action on my consent.

_____ _____
Signature of Patient/ Legal Guardian Date

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Office Policy

In order to improve our efficient and help ensure a pleasant office visit, please read the following:

- Please bring any current glasses or contact lenses with you to every visit.
- Please help us stay on schedule by arriving on time for your scheduled appointment. If you arrive more than 15 minutes late your appointment may need to be rescheduled.
- As a courtesy to staff and others in the waiting room, please turn off your cellular/ mobile telephone.
- When scheduling your appointment, please provide us with your insurance policy/ ID number and group number as well as the telephone numbers listed on the back of the insurance card. We will make every effort to verify your insurance coverage and benefits before the day of your visit.
- We contract and are “in network” with many PPO, POS, EPO and HMO insurance plans. If your plan requires a referral number, please provide this to us when scheduling your appointment. The referral is usually obtained from your Primary Care Physician (PCP).
- If we are contacted with your insurance plan, we will file your insurance claim for you. As stated in our Patient Financial Responsibility Statement, you are required to pay your co-pay and/or coinsurance and/or deductible amount (if not met for the year) at the time of your visit.
- If a parent or guardian cannot accompany the minor patient to the exam, a **written** authorization from the parent/ guardian must be presented by the person bringing the patient to the appointment. We are unable to examine the patient without this authorization.
- If the minor patient’s parents are divorced, payment is the responsibility of the parent bringing the child to the office for treatment, regardless of the terms of the divorce decree.
- In compliance with federal privacy policies, no information regarding a patient(s) will be released without written authorization from the patient, parent, or guardian. Please see the link for the Medical Records Release Form.

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Financial Responsibility

As a specialty practice we strive to keep our fees competitive and as low as we can. To accomplish that we feel it is important that we have a good understanding with our patients regarding financial responsibility. We hope this summary is helpful toward this goal and we encourage you to ask our staff any questions you may have.

- We must have a current copy of your medical insurance card. If this is not available, payment in full for the office visit will be expected at the time of service. We do not file claims to Vision Insurance plans.
- Any deductibles, coinsurance and co-payment amounts are due at the time of the service.
- If we are contracted with your insurance plan we will submit the remainder to your insurance carrier.
- If your insurance plan mistakenly sends payment directly to you, please send us a personal check as well as the paperwork from the insurance carrier.
- You are responsible for any services not covered by your insurance policy.
- Medical insurance plans will sometimes refuse to pay for a claim for any of the following reasons:
    - Pre-existing conditions
    - The individual or family deductible has not been met
    - The policy was not in effect at the time of service
    - There is another insurance policy that is considered primary
    - The type of service is not covered on your policy

Although we make every effort to verify your insurance benefits prior to the appointment date or at the time of service, the payment we collect may not reflect the full patient responsibility. Please be aware that financial responsibility for medical services is between you and your health plan/ insurance carrier. While we are happy to submit your insurance claim on your behalf, we are not responsible for any limitations or exclusions in your plan's coverage. If your insurance carrier denies your claim you will be responsible for payment in full.

Our mission is to provide you with excellent quality care at cost-effective, competitive pricing. We are constantly adapting to the changing policies of health insurance carriers and the federal government. We value you as a patient and welcome you to our practice.

I have read and understand my obligations. I acknowledge that I am fully responsible for payment of services if not covered by my insurance carrier or the practice is not contracted with my health plan. Any questions I may have had regarding this policy have been answered by the staff of Dr. Becky Luu/ Dr. Eurika Rajbanshi.

_____ _____

Patient or Guardian Signature *Date*

_____

Printed Name

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Becky Luu, OD, FAAO
Eurika Rajbanshi, OD

Consent for Procedure/ Treatment of a Minor Child

I authorize and direct Dr. Becky Luu OD, FAAO/ Dr. Eurika Rajbanshi OD and his or her assistants as necessary to perform quality care, procedure/treatment(s) upon my minor child.

Patient Name:_____ DOB: _____ Social Security # _____

This authorization is for _____ date of treatment.

The person(s) authorized to request treatment on my behalf is/are:

(1)_____ Relationship to patient _____

(2)_____ Relationship to patient _____

Patient or Legal Guardian Signature: _____ Date:_____

Please Note:

- **Signature of parent must match the signature on file in our office**
- **If a patient has never been seen in our office a copy of driver license must be attached**
- **If legal guardian is signing a copy of guardianship papers must be on file in our office**

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MEDICATION RECORD

Patient's Name: _____

Start Date:	Medication	Dose:	Frequency (I.E. 2x per day)	TIme:	Reason for medication: