



Welcome. We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we will be glad to help you.

PATIENT INFORMATION	
Date _____	
SS/HIC/Patient ID# _____	
Patient Name _____	
Last Name _____	
First Name _____	Middle Initial _____
Address _____	
City _____	
State _____	Zip _____
E-mail _____	
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Age _____ Birthdate _____
<input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> Minor	
<input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Partnered for _____ years	
Occupation _____	
Patient Employer/School _____	
Employer/School Address _____	
Employer/School Phone (____) _____	
Spouse's Name _____	
Birthdate _____ SS# _____	
Spouse's Employer _____	
Whom may we thank for referring you? _____	

INSURANCE
Who is responsible for this account? _____
Relationship to Patient _____
Insurance Co. _____
Group # _____
Is patient covered by additional insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No
Subscriber's Name _____
Birthdate _____ SS# _____
Relationship to patient _____
Insurance Co. _____
Group# _____
ASSIGNMENT AND RELEASE
I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to _____
Name of Insurance Company(ies) _____
Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all changes whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payments for services. The consent will end when my current treatment plan is completed or one year from the date signed below.
_____ Signature of Patient, Parent, Guardian or Personal Representative
_____ Please print name of Patient, Parent, Guardian or Personal Representative
_____ Date
_____ Relationship to Patient

PHONE NUMBERS
Home (____) _____ Cell (____) _____ Spouse's Work Phone (____) _____ Ext _____
Best time and place to reach you _____
IN CASE OF AN EMERGENCY, CONTACT (Specify someone who does not live in your household.)
Name _____ Relationship _____
Home (____) _____ Cell (____) _____ Work Phone (____) _____ Ext _____

EYE HEALTH HISTORY	
Physician's Name _____	Place a Mark on "Yes" or "No" to indicate if you have had any of the following:
Date of last visit _____	Bloodshot Eyes <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last eye exam _____	Bloodshot Vision - Distance <input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Doctor _____	Blurred Vision - Near <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you wear glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No	Burning Eyes <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> All the time <input type="checkbox"/> Occasionally	Cataracts <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Reading <input type="checkbox"/> Driving <input type="checkbox"/> TV	Color Vision, Poor <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you wear contacts? <input type="checkbox"/> Yes <input type="checkbox"/> No	Crossed Eyes <input type="checkbox"/> Yes <input type="checkbox"/> No
Type _____ Hours/Day _____	Discharge from Eyes <input type="checkbox"/> Yes <input type="checkbox"/> No
Describe any problems you have with your contacts _____	Dizzy Spells <input type="checkbox"/> Yes <input type="checkbox"/> No
	Double Vision <input type="checkbox"/> Yes <input type="checkbox"/> No
	Dry Eyes <input type="checkbox"/> Yes <input type="checkbox"/> No
	Eye Infection <input type="checkbox"/> Yes <input type="checkbox"/> No
	Eye Injury <input type="checkbox"/> Yes <input type="checkbox"/> No
	Eye Strain <input type="checkbox"/> Yes <input type="checkbox"/> No
	Fainting Spells, Blackouts <input type="checkbox"/> Yes <input type="checkbox"/> No
	Floaters or Spots <input type="checkbox"/> Yes <input type="checkbox"/> No
	Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No
	Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No
	Itching Eyes <input type="checkbox"/> Yes <input type="checkbox"/> No
	Light Sensitive <input type="checkbox"/> Yes <input type="checkbox"/> No
	Loss of Vision <input type="checkbox"/> Yes <input type="checkbox"/> No
	Migraine Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No
	Night Vision, Poor <input type="checkbox"/> Yes <input type="checkbox"/> No
	Red Eyes <input type="checkbox"/> Yes <input type="checkbox"/> No
	Seeing Halos <input type="checkbox"/> Yes <input type="checkbox"/> No
	Seeing Flashes <input type="checkbox"/> Yes <input type="checkbox"/> No
	Temporary Loss of Vision <input type="checkbox"/> Yes <input type="checkbox"/> No
	Twitching Eyelid <input type="checkbox"/> Yes <input type="checkbox"/> No
	Vision Poor <input type="checkbox"/> Yes <input type="checkbox"/> No
	Watering Eyes <input type="checkbox"/> Yes <input type="checkbox"/> No

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosure of their protected health information (PHI). The individuals is also provided the right to request confidential communications or tat a communication of PHI be made by alternative means such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

Home Telephone

- O.K. to leave message with detailed information
- Leave a message with call-back number only

Written Communication

- O.K. to mail to my home address
- O.K. to mail to my work/office address
- O.K. to fax to this number

Work Telephone

- O.K. to leave message with detailed information
- Leave a message with call-back number only

Other _____

Patient Signature	Date
Print Name	Birthdate

The Privacy Rule generally requires healthcare providers to take responsible steps to limit the use or disclosure of and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entitles must keep records of PHI disclosures. Information provided below if completed properly will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency

Date	Disclosed to Whom Address or fax Number	(1)	Description of Disclore / Purpose of Disclosure	By Whome Disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized
 (2) Type key: T=Treatment: P=Payment Information: O=Healthcare Operations
 (3) Enter how disclosure was made: F=Fax: P=Phone: E=Email: M=Mail: O=Other

HEALTH HISTORY

Physician's Name _____ Date of last visit _____
 Place a mark on "Yes" or "No" to indicate if you have had any of the following. Also place a mark to indicate if a blood relative has had any of the following problems.

	Yourself	Family Members		Yourself	Family Members
AIDS / HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis (Type _____)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valve	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lazy Eye	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lupus	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Migraine Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blindness	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Poor Color Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Retinal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shingles	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Drug Sensitivity	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Conditions	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Conditions	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eye Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Turned Eye	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hay Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you pregnant? _____	Number of children _____	
Heart Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tobacco use _____	Alcohol use _____	

MEDICATIONS

List any medications you are currently taking, including eye drops:

Pharmacy Name _____

Phone (____) _____

ALLERGIES

List your allergies to medications or other substances:

MEDICARE / MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable Medigap benefits, be made either to me or on my behalf to _____ for any services furnished to me by that provider.

Name of Doctor or Clinic

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or for related services.

_____ Date

Signature of Beneficiary, Guardian or Personal Representative

_____ Relationship to Beneficiary

Please print name of Beneficiary, Guardian or Personal Representative