PALMER EYECARE CENTER

Patient Registration/Information and Privacy Disclosure Form

Name _____ **Birth Date** _____/_____/_____
Mr/Mrs/Ms Last First MI MM / DD / YYYY

Address _____ **Social Security #** _____-_____-_____
Street City State Zip

Employer _____ **Home Phone** ( ) _____

Occupation_____ **Marital Status** __S __M __D __W **Work Phone** ( ) _____

Spouse's Name_____ **Cell Phone** ( ) _____

Emergency Contact and Phone _____ **Email** _____

Primary Care Physician_____ **City**_____ **Phone** ( ) _____

Pharmacy_____ **City** _____ **Phone** ( ) _____

Guarantor (who is paying?) _____ **Address** (if different) _____

Last Eye Exam was in 20_____ with Dr. _____ **Sex** __M __F **May we text you?** __Y __N

Preferred Language _____ **Preferred Communication** ___US Mail ___Telephone ___E-mail

How did you hear about our office? Ad in _____ ___Yellow Pages ___Provider Directory

Referred by _____ ___Newspaper ___Internet/Website

Race ___ Native American/Native Alaskan ___ Hispanic
___ Asian ___ Native Hawaiian/Other Pacific Island
___ Black/African American ___ White

Ethnicity ___ Hispanic/Latino
___ Native Hawaiian/Pacific Island
___ Not Hispanic/Latino

Eyecare/Vision Insurance Information

(a copy will be taken of your insurance card) **Primary/Major Medical** **Secondary/Vision Plan** (Prepaid Eyeglass Plan)

HMO/Ins. Company _____ _____

Name of Policy Holder _____ _____

Relationship to Insured ___Self ___Spouse ___Dependent ___Self ___Spouse ___Dependent

Financial Policy

You must bring your insurance card to each visit. As a courtesy, we will bill your insurance for services rendered. However, we must have all insurance and referral information provided to us BEFORE services are rendered or full payment will be required before you leave. Questions involving eligibility, deductibles, co-payments, benefits and overall coverage must be addressed with your carrier, not our office. Not all insurance plans include vision care. **In cases of multiple vision/health plan coverage, medical tests will be billed to medical insurance; vision testing and devices will be billed to vision plans.** Anything not covered is the responsibility of the patient. You are responsible for any fees not covered by your plan or insurance. A 1½% billing fee is added to outstanding balances over 30 days old. Accounts unpaid for 90 days are sent to collection. There is a $29 fee for returned checks. Patients are responsible for all costs associated with collection and/or legal actions.

I authorize the Palmer Eyecare Center to submit a claim to my insurance carrier and direct my insurance carrier to issue payment directly to the Palmer Eyecare Center, LLC. I authorize the release of any medical information to my health plan.

I ACCEPT FULL FINANCIAL RESPONSIBILITY FOR ALL CHARGES AND FEES RELATED TO MY MEDICAL TREATMENT AND VISION CORRECTION DEVICES.

"Notice of Privacy Practices" Receipt

In the course of providing services to you, we create, receive and store identifying health information. It is often necessary to use and disclose this information in order to treat you, obtain payment for services, and to conduct healthcare operations involving our office. The "Notice of Privacy Practices" you have been given describes these uses and disclosures in detail.

I acknowledge receiving the "Notice of Privacy Practices" from the Palmer Eyecare Center.

_____ _____ _____
Lifetime Authorization Signature of Patient or Representative **(Specify Relationship)** **Date**

Updated: _____ _____ _____ _____ _____ _____ _____ _____

PALMER EYECARE CENTER

Patient/Family Health History (use another sheet if more space is needed)

Patient Name: _____ Last Physical Exam: _____ /_____
Month / Year

Do you have special visual requirements for computers, work (safety glasses), sports (fishing), driving (night) or hobbies? _____

_____

Please list all your current medications (include over the counter, vitamins and herbal therapy): _____

_____

List all major surgeries (including eye and laser surgery): _____

_____

List any allergic reactions to medications or eye drops: _____

_____

Do you wear: □ Eyeglasses □ Contact Lenses? Do you have a spare pair of glasses? □ Yes □ No Do you have sunglasses? □ Yes □ No

Do you use artificial tears? □ Yes □ No WOMEN- Are you pregnant? □ Yes □ No Are you breast feeding? □ Yes □ No

Please indicate if any of these eye or medical conditions apply to you or a family member (blood relatives only).

Family Member	You	Condition	Relationship
□	□	Blindness	_____
□	□	Cataract	_____
□	□	Eye Turn/Strabismus	_____
□	□	Glaucoma	_____
□	□	Keratoconus	_____
□	□	Lazy Eye/Amblyopia	_____
□	□	Macular Degeneration	_____
□	□	Retinal Detachment	_____
□	□	Cancer (Type _____)	_____
□	□	Diabetes	_____
□	□	Headaches/Migraines	_____
□	□	Hypertension	_____
□	□	Retinal Disease	_____
□	□	Other: _____	_____

Have you ever had:

□ Burning/Itching/Allergies □ ADD/ADHD
□ Crusty, Gritty Feeling □ Something in Eye
□ Double Vision □ Distortion of Vision
□ Droopy Eyelids □ Dyslexia
□ Dry Eyes □ Watery Eyes
□ Eye Ache or Pain □ Pink Eye/Red Eye
□ Flashes of Light □ Floaters
□ Glare/Halos Around Lights □ Light Sensitivity
□ Infection of the Eye or Lid □ Puffy Lids/Sties
□ Loss of Vision in One Eye
□ Loss of Central/Side/Top/Bottom Vision
□ Mucous Discharge from Eye

When reading, do:
□ words run together? □ you lose your place easily?

Review of Systems: Please indicate below if you currently have or have ever had problems with the following conditions or symptoms:

Allergic/Immunologic
□ None □ Lupus □ Lyme Disease
□ Food Allergy □ Seasonal Allergy
□ Environmental Allergy (latex,dust)
□ Rheumatoid Arthritis □ Hives
□ Autoimmune Disorder/Sjogren's
□ Other _____

Ear, Nose and Throat
□ None
□ Sinusitis □ Hearing Loss
□ Ringing in Ears/Tinnitus
□ Nose Bleeds
□ Dry Mouth □ Sore Throat
□ Other _____

Gastrointestinal
□ None □ Diarrhea
□ Heartburn □ Vomiting
□ IBD/Colitis/Crohn's
□ Acid Reflux/Ulcer
□ Liver Disease/Hepatitis
□ Other _____

Skin/Integumentary
□ None
□ Eczema/Psoriasis
□ Rosacea
□ Pimples/Warts/Growths
□ Itchiness/Dryness/Rashes
□ Other _____

Psychiatric
□ None
□ Anxiety/Depression/Stress
□ Bi-Polar
□ Schizophrenia
□ Panic Episodes
□ Other _____

Cardiovascular
□ None □ Stroke □ Angina
□ High Blood Pressure
□ Heart Disease □ Heart Attack
□ High Cholesterol
□ Vascular Disease
□ Other _____

Endocrine/Glands
□ None
□ Diabetes
□ Hormone Dysfunction
□ Pituitary Dysfunction
□ Thyroid Dysfunction
□ Other _____

Respiratory
□ None □ Tuberculosis
□ Asthma/Bronchitis
□ Sleep Apnea □ Sarcoid
□ Emphysema □ COPD
□ Upper Respiratory Inf.
□ Other _____

Muscle/Skeletal
□ None □ None
□ Arthritis
□ Fibromyalgia
□ Ankylosing Spondylitis
□ Joint/Muscle Pain
□ Other _____

Genital/Urinary
□ Kidney Disease
□ Urinary Tract Infection
□ HIV Positive/AIDS
□ Herpes/Chlamydia
□ Blood in Urine
□ Other _____

Hematologic/Lymphatic
□ None □ Swollen Glands
□ Anemia □ Bruise Easily
□ Leukemia/Lymphoma
□ Bleeding or Blood Disorder
□
□ Other _____

Neurological
□ None □ Bell's Palsy
□ Multiple Sclerosis □ Vertigo
□ Epilepsy □ Stroke
□ Tremors/Seizures/Blackouts
□ Numbness/Weakness
□ Other _____

General Health
□ Good Overall
□ Rapid Weight Loss/Gain
□ Fever/Chills □ Sweats
□ Fatigue □ Insomnia
□ Dizziness □ Fainting
□ Trauma □ Snoring

Social
□ Tobacco Use:
□ Current Smoker □ Former Smoker #/day_____
□ Recreational Drugs _____
□ Alcohol Consumption_____ oz./day_____
□ Exercise: □ Regularly □ Occasionally □ Rarely
□ Weight_____ Height_____

Please sign below to acknowledge that this form is current:

Signature: _____ Date: _____ Reviewed by Doctor's initials: _____

Updated: _____ _____ _____ _____ _____ _____ _____ _____