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 #** LAST 4 DIGITS _____
Street City State Zip ⇩ PLEASE CONTACT ME HERE

Employer _____ ❒**Your Home Phone** ( )_____

Occupation_____ **Marital Status** S__ M__ D__ W___ ❒**Your Work Phone** ( )_____

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

Emergency Contact and Phone _____ ❒ **Email** _____

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

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

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

Sex M___ F___ **Preferred Pronoun _____ Last Eye Exam was in 20____ with Dr**. _____ **May we text you?** Y__ N__

Preferred Language (English is spoken here)_____ **Preferred Communication** ❒ US Mail ❒ Telephone ❒ E-mail ❒ Text

How did you hear about our office? Ad in _____ ❒ Google/Internet/Facebook ❒ Provider Directory

Referred by _____ ❒ Newspaper/Magazine Ad ❒ Doctor/Friend

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

Eye Care/Vision Insurance Information

(a copy will be taken of your insurance card) **Primary/Major <u>Medical</u>** **Secondary/<u>Vision</u> Plan** (Discount Eyeglass Plan like VSP/EyeMed)

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 <u>each</u> visit. As a courtesy, we will bill your insurance for services rendered. However, we must have all insurance and referral information provided to us <u>BEFORE</u> 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 coverages, medical tests will be billed to medical insurance; vision testing and vision correction devices will be billed to vision plan.** 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. Patients are responsible for all costs associated with collection and/or legal actions. There is a $39 fee for returned checks. There is a $35 broken appointment fee for patients who fail to notify the office within 24 hours that they will miss their reserved time.

I authorize the Palmer Eyecare Center, LLC 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 required medical diagnostic information to my health plan. I further assign to the Palmer Eyecare Center, LLC all rights afforded to me under ERISA with respect to the services rendered, including the right to bring an action to enforce ERISA and my ERISA rights.

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.

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

Updated: _____ _____ _____ _____ _____ _____ _____ _____

<u>OVER - Please fill out BOTH sides</u>➔

PALMER EYECARE CENTER

Page 2 **Patient/Family Health History** (please 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? _____

Do you use a: ❒ Laptop? ❒ Desktop? ❒ Smartphone? Do you have **multiple monitors**? ❒ **Yes** ❒ **No** Approximate distance to monitors_____inches

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

_____

List any **allergies** to medications or anything else: _____

_____

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

_____

Do you wear: ❒ **Eyeglasses** ❒ **Contact Lenses**? By the end of the day, do they ❒ dry out ❒ get scratchy ❒ vision fluctuates? Do eyes get red? ❒ **Yes** ❒ **No**

Do you have spare pair of glasses? ❒ **Yes** ❒ **No** Do you use sunglasses? ❒ **Yes** ❒ **No** Do you get **MIGRAINES** that make you light sensitive? ❒ **Yes** ❒ **No**

Do you have dry, gritty, scratchy eyes? ❒ **Yes** ❒ **No** Use artificial tears? ❒ **Yes** ❒ **No** WOMEN: Are you pregnant? ❒ **Yes** ❒ **No** Breast feeding? ❒ **Yes** ❒ **No**

Does your vision fluctuate during the day? ❒ **Yes** ❒ **No** Is it difficult to get to **sleep** at night? ❒ **Yes** ❒ **No** Is it hard to focus or see up close? ❒ **Yes** ❒ **No**

FMH

Please indicate if any of these eye or medical conditions apply (blood relatives only).

HPI

Family Member	You	HAS ANYONE IN YOUR FAMILY EVER HAD: Condition	Relationship
❒	❒	Blindness	_____
❒	❒	Cataract	_____
❒	❒	Eye Turn/Strabismus	_____
❒	❒	**Glaucoma**	_____
❒	❒	Keratoconus	_____
❒	❒	Lazy Eye/Amblyopia	_____
❒	❒	**Macular Degeneration**	_____
❒	❒	Retinal Detachment	_____
❒	❒	Retinal Disease	_____
❒	❒	Cancer (Type _____)	_____
❒	❒	**Diabetes**	_____
❒	❒	**Headaches/Migraines**	_____
❒	❒	Hypertension	_____
❒	❒	Other: _____	_____

DO YOU CURRENTLY HAVE:

❒ ADD/ADHD ❒ Floaters
❒ Burning/Itching/Allergies ❒ Glare/Halos Around Lights
❒ Crusty, Gritty Feeling ❒ Infection of the Eye or Lid
❒ Distortion of Vision ❒ Light Sensitivity
❒ Double Vision ❒ Loss of Vision in One Eye
❒ Droopy Eyelids ❒ Mucous Discharge from Eye
❒ Dry Eyes ❒ Pink Eye ❒ Red Eye
❒ Dyslexia/Reverses Letters ❒ Puffy Lids ❒ Styes
❒ Eye Ache or Pain ❒ Something in Eye
❒ Flashes of Light ❒ Watery Eyes
❒ Loss of Central or Side or Top or Bottom Vision
When reading, do:
❒ words run together? ❒ you lose your place easily?
Do you ever get car sick? ❒ Yes
Do you ever have problems seeing 3D movies? ❒ Yes

ROS

Please indicate below if you now have or have ever had serious problems with the following systemic conditions or symptoms:

Allergic/Immunologic
❒ **None** ❒ Lupus ❒ Lyme Disease
❒ Allergies: Foods, Latex, Dust, etc.
❒ Autoimmune Disorder/Sjogren's
❒ Herpes ❒ Sarcoid ❒ HIV/AIDS
❒ Rheumatoid Arthritis ❒ Hives
❒ Other _____

Ear, Nose and Throat
❒ **None** ❒ Chronic Cough
❒ Dental or Mouth Problems
❒ Nose Bleeds ❒ Sore Throat
❒ Ringing in Ears/Tinnitus
❒ Sinusitis ❒ Hearing Loss
❒ Other _____

Gastrointestinal
❒ **None** ❒ Diarrhea
❒ Acid Reflux ❒ Ulcers
❒ Heartburn ❒ Vomiting
❒ IBD/Colitis/Crohn's
❒ Liver Disease/Hepatitis
❒ Other _____

Skin/Integumentary
❒ **None** ❒ Dermatitis
❒ Eczema/Psoriasis
❒ Itchiness/Dryness/Rashes
❒ Pimples/Warts/Growths
❒ Rosacea/Impetigo/Acne
❒ Other _____

Psychiatric
❒ **None** ❒ ADHD
❒ Anxiety/Depression/Stress
❒ Bi-Polar ❒ Memory Loss
❒ Panic Episodes ❒ Dementia
❒ Schizophrenia ❒Alzheimers
❒ Other _____

Cardiovascular
❒ **None** ❒ Stroke ❒ Angina
❒ Hypertension ❒ Heart Attack(MI)
❒ Heart Disease ❒ Arrhythmia
❒ High Cholesterol
❒ Vascular Disease
❒ Other _____

Endocrine/Glands
❒ **None** ❒ Hyper/Hypoglycemia
❒ Diabetes ❒ Gout
❒ Hormone Disorder
❒ Pituitary Disorder
❒ Thyroid Disorder
❒ Other _____

Respiratory
❒ **None** ❒ TB ❒ Cystic Fib
❒ Asthma/Bronchitis
❒ Sleep Apnea ❒ Sarcoid
❒ Emphysema ❒ COPD
❒ Upper Respiratory Inf.
❒ Other _____

Muscle/Skeletal
❒ **None** ❒ Arthritis
❒ Ankylosing Spondylitis
❒ Fibromyalgia/Polymyalgia
❒ Gout ❒ Joint/Muscle Pain
❒ Muscular Dystrophy
❒ Other _____

Genital/Urinary
❒ **None** ❒ Bladder Problem
❒ Blood in Urine ❒Menopause
❒ Herpes/Chlamydia
❒ Kidney Disease ❒ Prostate
❒ Urinary Tract Infection
❒ Other _____

Hematologic/Lymphatic
❒ **None** ❒ Anemia
❒ Bruises Easily ❒ Sickle Cell
❒ Bleeding or Blood Disorder
❒ Leukemia/Lymphoma
❒ Swollen Glands
❒ Other _____

Neurological
❒ **None** ❒ Bell's Palsy ❒Stroke
❒ Cerebral Palsy ❒ Epilepsy
❒ Migraines ❒ MS ❒ Vertigo
❒ Numbness/Weakness ❒ TBI
❒ Tremors/Seizures/Blackouts
❒ Other _____

Constitutional/General Health
❒ **Good Overall** ❒ Sweats
❒ Dizziness ❒ Fatigue
❒ Fever/Chills ❒ Insomnia
❒ Nausea ❒ Nosebleeds
❒ Rapid Weight Loss/Gain
❒ Thirsty ❒ Fainting
❒ Other _____

Social
Tobacco Use: ❒ Former Smoker Quit When?____ yrs ago
❒ Current Smoker #/day_____ For_____years
Recreational Drugs_____
Alcohol Consumption _____drinks/day
Exercise: ❒ Regularly ❒ Occasionally ❒ Rarely

Weight_____ **Height**_____

Please sign below and initial annually to acknowledge that this form is current:

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

Updated: _____ _____ _____ _____ _____ _____ _____

OVER - Please fill out BOTH sides➔