PATIENT INFORMATION

Date_____

Patient Name_____
LAST FIRST MI

Address_____

City_____ State_____ Zip_____

Home/Cell_____ Work_____

Birthdate_____ Age_____ SSN_____

E-mail_____ Sex: MALE FEMALE

MARRIED SINGLE DIVORCED SEPERATED WIDOWED MINOR

Employer_____ Occupation_____

Spouse's Name_____ Birthdate_____

Referred by: DOCTOR INSURANCE COMPANY GOOGLE/INTERNET ANOTHER PATIENT

Name_____

INSURANCE

Insurance Company_____ Policy/Contract #_____

Secondary Insurance Company_____ Policy/Contract #_____

Who is responsible for this account?_____ Relationship to this patient?_____

Insured's Name_____ Birthdate_____ SS#_____

Address_____ City, State, Zip_____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with_____
NAME OF INSURANCE COMPANY(IES)
and assign directly to Dr._____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my healthcare information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable to related services. This 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 Rep.

_____ _____
Date Relationship to Patient

ALL EXAM FEES/ COPAYS DUE AT TIME OF VISIT.

Patient Name_____ **Date**_____

Circle problems you are having with your eyes: blurred vision: near/ far/ both right/ left/ both spots/ floaters lost/ broke/ scratched glasses contact lens problems/ update glasses problems/ update

Last eye exam?_____ Do you wear glasses? Y N If yes, what type: single bifocal trifocal progressive

Do you wear contact lenses? Y N If yes, what brand?_____ Do you sleep in your contacts?_____

If yes, how often do you remove?_____ How often do you throw your lenses away?_____

Circle if *YOU* have any history of the following conditions:

Diabetes	Glaucoma	Macular degeneration
High Blood Pressure	Cataracts	Blindness/Lazy eye
High Cholesterol	Retinal detachment	Eye Injury/ Surgery
Depression/Anxiety	Kidney Disease	Recurrent eye infections
Stroke	Heart Disease	Emphysema/COPD
Arthritis	Thyroid Disease	Seizure/Epilepsy
Cancer (site_____)		Headaches/Migraines: How often?_____

DIABETICS ONLY: Primary care doctor_____ What type 1, 2, gestational?
How long have you been diabetic?_____ yrs. What was the results of your last finger stick?_____ Last A1C?_____

Does anyone in your immediate family have the following:
(MOTHER, FATHER, BROTHER, SISTER, GRANDPARENTS)

Diabetes	High Blood pressure	Glaucoma
Cataracts	Retinal detachment	Macular degeneration

List all medications and supplements you currently take:

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

List all drug allergies:

_____ _____ _____ _____

List any surgeries:

_____ _____ _____ _____
_____ _____ _____ _____

Do you smoke/chew? Yes No Have you ever? Yes No Do you drink? Yes No

It is our goal to provide you with a complete comprehensive eye examination. To accomplish our goal, we feel at times it is important to dilate the pupils of your eyes. This will require placing drops in your eyes, which allow a better view of the inside of your eyes. As with many medications, there are some side effects of the drops used to dilate the pupil. These include, but are not limited to, light sensitivity and blurred near vision (in most cases distance vision will be unaffected). The side effects can last several hours and in some cases may last as long as 24 hours.

While we believe dilation is an important part of the eye examination process, we understand that you may wish to refuse this procedure.

PLEASE INITIAL ONE ONLY:

_____ **I agree to be dilated if the doctor deems it necessary based on the information I have provided.**
Initial

_____ **I do not wish to be dilated today and agree to hold the doctor harmless as a result of my actions.**
Initial

HIPAA PRIVACY POLICY PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health insurance portability and accountability act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry on:

-Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)

-Obtaining payment from third party payers (i.e. my insurance company)

-On the day to day healthcare operation of your practice.

I have also been informed of and/or given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do not agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing at anytime. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Date_____

Print patient name_____

Relationship to Patient_____

Signature _____

Dr. Jo Ann Graffeo-King Eye Care @ Eye Express
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