ELIZABETHTOWN EYE CARE

Patient Registration

PLEASE PRINT

<u>CONFIDENTIAL</u>

Name:		Date of Birth:	MALE FEMALE
Address:			
City:		State:	Zip Code:
Home Phone:	Cell Phone:	Email Address:	
Social Security No.:	Single Divorced Married Widowed	Occupation and Employer:	
Preferred Language:	Race:	Ethnicity: Hispanic or Latino	Not Hispanic or Latino
Spouse/Parent Name:		Occupation and Employer:	
Friend/Relative (Not living with you):		Phone Number:	
Power of Attorney (If applicable):		Phone Number:	
Family Doctor (Name and Location):		Pharmacy (Name and Location):	

INSURANCE INFORMATION

Primary:	Policy Holder:	Date of Birth:	Social Security No.:
Secondary:	Policy Holder:	Date of Birth:	Social Security No.:
How did you hear about us?		Referring Doctor:	

Payment is requested at time of service. We accept cash, check, Visa, MasterCard, Discover, and Care Credit.

I agree that the above information is true. I authorize assignment of all vision, medical and/or surgical benefits to Etown Eyecare. I authorize the release of any vision, medical, and/or surgical information necessary to process any insurance claims. I understand that it is my responsibility to know the type and extent of my insurance coverage, not my healthcare provider. I also understand that in the event that my insurance does not pay, I am responsible for any unpaid balance. I agree to be held liable for any expenses and/or collection agency fee for any outstanding balance.

Signature of Patient/Responsible Party:	Date:

E-TOWN EYECARE

Patient Name:	**Date:**

Reason for today's exam:		
Date of last exam:	*Doctor's Name:*	
Do you currently wear glasses?	*When do you wear your glasses?* full time / distance vision / reading/near vision / safety/work	
Do you currently wear contacts?	*What brand/type?*	How often do you replace your contacts?
Are you interested in contacts?	*If so, what type or brand?* Disposable / Colors / Soft / Bifocal / Toric / Hard	

Questions or comments?

ELIZABETHTOWN EYE CARE

PLEASE FILL OUT THIS COMPREHENSIVE HEALTH HISTORY

CONFIDENTIAL

REVIEW OF SYSTEMS

Patient Name: ______________________ **Date:** ____________

Approximate Height: ____________ ***Approximate Weight:*** ____________

PLEASE CHECK YES OR NO		YES	NO
Allergic/Immunology	HIV/AIDS		
	Seasonal Allergies		
	Sinus Problems		
Cardiovascular	Angina		
	Heart Attack		
	High Blood Pressure		
Constitutional Systems	***GOOD GENERAL HEALTH***		
	Fever		
	Recent Weight Loss		
Endocrine	Diabetes (pill/insulin)		
	Thyroid Disorder		
Gastrointestinal	Gallstones		
	Hepatitis		
	Peptic Ulcer		
Genitourinary	Kidney Stones		
	Venereal Disease		
Gastrointestinal/Lymphatic	Anemia		
	Bleeding Disorder		
	Swollen Lymph Glands		
Musculoskeletal	Osteoarthritis		
	Rheumatoid Arthritis		
Neurological	Migraine		
	Seizure		
	Stroke		
Psychiatric	Anxiety		
	Depression		
Respiratory	Asthma		
	Emphysema		
	Tuberculosis		

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING	
NAME OF MEDICATION	*FREQUENCY*

ALLERGIES
PLEASE LIST ANY ALLERGIES TO MEDICATIONS

PAST MEDICAL HISTORY
MAJOR ILLNESSES OR INJURIES
SURGERIES

FAMILY MEDICAL HISTORY		
PLEASE CIRCLE YES OR NO		
BLINDNESS	YES	NO
CANCER	YES	NO
CROSSED EYES	YES	NO
DIABETES	YES	NO
HEART DISEASE	YES	NO
MACULAR DEGENERATION	YES	NO
RETINA DISEASE	YES	NO
GLAUCOMA	YES	NO

SOCIAL HISTORY		
OCCUPATION:		
ALCOHOL USE?	YES	NO
TOBACCO USE?	YES	NO

DOCTOR'S INT. ____________

TECH'S INT. ____________

PATIENT SIGNATURE: ______________________

ELIZABETHTOWN EYE CARE
DR. CRISTINA PATRICK
103 Diecks Drive
Elizabethtown, KY 42701
270-769-1397
Office Contact: Paige Stansberry

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

PATIENT NAME: ____

I understand that as part of my healthcare, ELIZABETHTOWN EYE CARE maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I authorize the professional office of ELIZABETHTOWN EYE CARE to release health information identifying me under the following terms:

- A basis for planning my care and treatment
- A means of communication among health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can certify that services billed were actually provided

I understand and have been provided with a NOTICE OF PRIVACY PRACTICES that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice of prior to signing this consent
- The right to object to the use of my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care options

It is completely your decision whether or not to sign this authorization form. We cannot refuse treatment if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written request telling us that you want your authorization revoked. Send this to the office contact person listed at the top of this form.

When your health information is disclosed, as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes.

I wish to have the following restrictions to the use or disclosure of my health information:

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I understand that I must give written permission for E-TOWN EYECARE to disclose any information to a *spouse or family member.*

I give ELIZABETHTOWN EYE CARE permission to disclose my personal health information to the following:

Name: ______________________________ Phone Number: ______________

Name: ______________________________ Phone Number: ______________

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

PATIENT SIGNATURE: ______________________________ ***DATE***: ______________

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient: ______________ Print Name: ______________________________

Elizabethtown Eye Care Representative: ______________________________ ***DATE:*** ______________