THE EYE GROUP ASSOCIATES PC & THE EYE GROUP DISPENSARY LLC

PATIENT INFORMATION REGISTRATION FORM

ACCT #_____

PERSONAL:

Name:_____

Address:_____
City State Zip

Primary Phone #_____ if Cell then Carrier:_____

Alternate phone #_____ *work* *home* *other*

Email address: (for future communications)_____

Date of Birth:_____ SSN:_____

Primary Care Physician_____ Phone_____

INSURANCE:

MEDICAL Insurance_____ ID# _____

Subscriber name_____ Group #_____

Relationship to patient: Self Spouse Father Mother Domestic Partner

Employer_____ or RETIRED

REQUIRES PCP REFERRAL: *YES* *NO*

VISION Insurance:_____ ID #_____

Subscriber name_____ Group #_____

Relationship to patient: Self Spouse Father Mother Domestic Partner

Pharmacy:_____ Phone:_____

Who may we thank for your referral to our office ?_____

Patient Signature: *(guardian if minor)*_____ *Date:*_____

Medical History Form

NAME: _____ DATE: _____

For our records we need the following updated information:

Name of pharmacy and location: _____

Current Blood Pressure_____/_____ or unknown Height: _____ Weight: _____

Do you use tobacco? No_____ Yes_____ Approximate date you stopped_____
Do you drink alcohol? No_____ Yes – Occasionally _____Socially_____ Regularly_____
Any recreational drug use: No_____ Yes_____ Please list: _____

List **ALL** medications you take for general health or **see attached list:**

_____

_____

Any **Allergies** to medications: _____
Any seasonal allergies: _____ Food allergies: _____
List all **eye drops** used: _____

Ocular Symptoms & History: Please check all symptoms that currently apply to you.

- ☐ Loss of vision
- ☐ Blurred vision
- ☐ Light flashes
- ☐ Floaters
- ☐ Glare
- ☐ Halos around lights
- ☐ Light sensitivity
- ☐ Burning
- ☐ Crusting or discharge
- ☐ Red eyes
- ☐ Irritated or itching eyes
- ☐ Dryness
- ☐ Headache or migraine
- ☐ Pain in or around eyes
- ☐ Excess tearing or watering
- ☐ Double or distorted vision

Other Eye Diseases or Symptoms:

_____

_____

Past Eye Surgeries_____

- ☐ Diabetes: Year of onset_____ Insulin medication diet controlled
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Stroke
- ☐ Cancer:_____
- ☐ Thyroid Disorder- type_____

Other: _____

Past Surgeries: _____

_____

Family History: After each, indicate M-mother, F-father, S-sister, B-brother

- ☐ Cataract_____
- ☐ Glaucoma_____
- ☐ Mac Degeneration_____
- ☐ Retinal Detachment_____
- ☐ Retinal Disease_____
- ☐ Blindness_____
- ☐ Diabetes_____
- ☐ Migraines_____
- ☐ Hypertension_____
- ☐ Heart Disease_____
- ☐ Stroke_____
- ☐ Cancer_____
- ☐ Other:_____

_____

THANK YOU! The detailed information you provide will help us provide you with the best care possible.

THE EYE GROUP ASSOCIATES, PC
ACKNOWLEDGMENT AND CONSENT

I understand that ***THE EYE GROUP ASSOCIATES, PC & THE EYE GROUP DISPENSARY, LLC*** (referred to below as "This Practice" which will include both businesses) will use and disclose **health information** about me.

I understand that my **health information** may include information both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, demographics and similar types of health-related information.

I understand and agree that *This Practice* may **use and disclose** my health information in order to:

- make decisions about and plan for my care and treatment;
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive a written description of how *This Practice* will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of This Practice, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy of the most current version of This Practice's **Notice of Privacy Practices** in effect will be posted in *This Practice's* reception or bookkeeping area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that *This Practice* is not required by law to agree to such requests.

At The Eye Group Associates, PC and Eye Group Dispensary, LLC, we strive to provide quality healthcare and premium services and have established our payment policy to avoid any financial misunderstandings. Co-payments required by insurance are due at the time of service and if not paid at the time of service, are subject to a $15 service fee. Insurance billing requires a current insurance card and if one is not provided, you may be billed directly. And, delinquent accounts may be assigned to our collection agency, Asset Recovery, and will need to be satisfied thru the agency.

By signing (or initialing) below, I agree that I have received and reviewed the information above and I have received a copy of the Notice of Privacy Practices for THE EYE GROUP ASSOCIATES, PC. and THE EYE GROUP DISPENSARY, LLC.

By:_____ Date:_____
(patient)

-OR-

By:_____ Date:_____
(patient representative)