

# NEW PATIENT REGISTRATION

In order to provide you the best possible care, please complete this form and bring it to your first appointment. All information is strictly **CONFIDENTIAL**.

Contact Information			
First Name	_____	Street Address	_____
Last Name	_____	Suite/Apt.	_____
Daytime Phone	_____	City	_____
Mobile Phone	_____	State	_____
Email	_____	Zip Code	_____

Guardian Information <i>(if patient is under 18 years of age)</i>			
First Name	_____	Street Address	_____
Last Name	_____	Suite/Apt.	_____
Daytime Phone	_____	City	_____
Mobile Phone	_____	State	_____
Email	_____	Zip Code	_____

Patient Information		Primary Insurance Information	
Gender	_____	Provider Name	_____
Date of Birth	_____	Provider Phone	_____
Social Security No.	_____	Policy/I.D. No.	_____
		Group No.	_____

Secondary Insurance Information		Additional Insurance Information	
Provider Name	_____	Provider Name	_____
Provider Phone	_____	Provider Phone	_____
Policy/I.D. No.	_____	Policy/I.D. No.	_____
Group No.	_____	Group No.	_____

Financial Assignment Information	Acknowledgment of Notice of Privacy Practices (NPP)
<p>I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.</p>	<p>Yes, I have read or had explained to me by this office the NPP &amp; I wish to continue my care under said terms.</p> <p>No, I have not read this office's NPP but I was given the opportunity to read it and declined. I wish to continue my care under said terms.</p> <p>The NPP could not be read due to the emergent nature of the care needed.</p>

Signature agreeing to all above terms \_\_\_\_\_ Date \_\_\_\_\_

# PATIENT HISTORY

## Vision Correction History *(please check any that apply)*

Amblyopia (lazy eye)	Fluctuating vision	Loss of vision
Blurred vision at a distance	Foreign body sensation	Mucous discharge
Blurred vision at near	Halos	Redness
Burning	I experience regular headaches	Sandy or gritty feeling
Double vision	I stopped wearing contact lenses	Sensitivity to light/glare
Drooping eyelid(s)	I stopped wearing glasses	Strabismus (crossed eye)
Dryness	Infection of eye or lid	Tired eyes
Eye pain and/or soreness	Itching	Watery eyes
Floaters or spots	Loss of peripheral vision	

## Glasses History *(check all that apply)*

### What glasses do you own?

Backup pair	Safety glasses
Bifocals	Single vision
Distance	Sports glasses
Progressive lens	Sunglasses
Reading	Trifocals
Other:	

### Check any that apply

- Allergic to nickel (frames)
- I do not want to wear glasses
- Incorrect prescription
- Need spare glasses
- Need sunglasses with UV
- Problems with current glasses
- Problems with glare
- Problems with night vision

How many hours per day do you spend using a computer? \_\_\_\_\_

## Contact Lens History *(check all that apply)*

What brand of contacts do you wear?	_____
How old are your current contacts?	_____
How often do you replace them?	_____
What solution do you use for soaking?	_____
What is your typical wearing schedule?	_____

### Check any that apply

- I do not want to wear contacts
- Incorrect prescription
- Interested in non-surgical correction
- Interested in refractive laser surgery
- Need spare contacts
- Problems with current contacts
- Would like to change my eye color

## Family History *(check all that apply)*

Blindness	Hypertension
Diabetes	Macular degeneration
Eye turn/lazy eye	
Glaucoma	

## Allergies *(please list)*

None

# PATIENT HISTORY

## General Medical History *(please answer appropriately)*

When (approx.) was your last eye exam? \_\_\_\_\_

Primary care physician name \_\_\_\_\_

Primary care physician phone \_\_\_\_\_

Please list all eye conditions you have experienced:

Surgeries:

### Do you have any of the following?

Arthritis

Asthma

Cancer

Diabetes

Heart disease

High cholesterol

HIV

Hypertension (high blood pressure)

Migraines/headaches

Multiple sclerosis (MS)

Other:

## Referral Information

### Why did you visit us?

Referred by your doctor

Visited our website

Found us on social media

Referred directly

### Keep in touch

Facebook email \_\_\_\_\_

@Twitter handle \_\_\_\_\_

## Questions and notes

**Do you have a question? Concern? We want to know.**

## **How We Collect Information About You**

We collect data through a variety of means including but not necessarily limited to letters, phone calls, emails, voicemails, and from the submission of applications that are either required by law or necessary to process applications or other requests for assistance through our organization.

## **What We Do Not Do With Your Information:**

Information about your financial situation and medical conditions and care that you provide to us in writing, via email, on the phone (including information left on voicemails), contained in or attached to applications, or directly or indirectly given to us, is held in strictest confidence.

We do not give out, exchange, barter, rent, sell, lend, or disseminate any information about applicants or clients who apply for or actually receive our services that are considered patient confidential, restricted by law, or specifically restricted by a patient/client in a signed HIPAA consent form.

## **How We Do Use Your Information:**

Information is only used as is reasonably necessary to process your application or to provide you with health or counseling services which may require communication between us and health care providers, medical product or service providers, pharmacies, insurance companies, and other providers necessary to verify your medical information is accurate and determine the type of medical supplies or health care services you need. This is including, but not limited to, or to obtain or purchase any type of medical supplies, devices, medications, or insurance.

If you apply or attempt to apply to receive assistance through us and provide information with the intent or purpose of fraud or that results in either an actual crime of fraud for any reason including willful or un-willful acts of negligence whether intended or not, or in any way demonstrates or indicates attempted fraud, your non-medical information can be given to legal authorities including police, investigators, courts, and/or attorneys or other legal professionals, as well as any other information as permitted by law.

## **Information We Do Not Collect:**

We do not use cookies on our website to collect data from our site visitors. We do not collect information about site visitors except for one hit counter on the main index page ([www.yourwebpage.org](http://www.yourwebpage.org)) that simply records the number of visitors and no other data. We do use some affiliate programs that may or may not capture traffic data through our site. To avoid potential data capture that you visited a diabetes website simply do not click on any of our outside affiliate links.

## **Limited Right to Use Non-Identifying Personal Information From Biographies, Letters, Notes, and Other Sources:**

Any pictures, stories, letters, biographies, correspondence, or thank you notes sent to us become the exclusive property. We reserve the right to use non-identifying information about our clients (those who receive services or goods from or through us) for fundraising and promotional purposes that are directly related to our mission.

Clients will not be compensated for use of this information and no identifying information (photos, addresses, phone numbers, contact information, last names or uniquely identifiable names) will be used without the client's express advance permission.

You may specifically request that NO information be used whatsoever for promotional purposes, but you must identify any requested restrictions in writing. We respect your right to privacy and assure you no identifying information or photos that you send to us will ever be publicly used without your direct or indirect consent.