PATIENT INFORMATION SHEET

Last Name _____ **First Name** _____ **Middle** _____

SSN _____ **DOB** _____ **Gender** _____

Street _____ **Apt** _____ **City** _____ **State** _____ **Zip** _____

Race _____ **Language** _____ **Hispanic or Latino: Yes / No**

Marital Status: Single / Married / Partner / Divorced / Widowed **Student Status: Full Time / Part Time**

CONTACT INFORMATION

Home Phone: _____

Day Phone: _____

Cell Phone: _____

Emergency Phone: _____

e-mail: _____

Primary Care MD: _____

Address: _____

Phone: _____ **Fax:** _____

Referring MD: _____

Address: _____

Phone: _____ **Fax:** _____

PRIMARY INSURANCE (For Personal Injury Cases, Please Ask for the Worker's Comp/MVA Form)

Payer Name: _____ **Effective Date:** _____

Insured ID: _____ **Insured Name (if not patient):** _____

Insured DOB (if not patient): _____

Insured Relationship to patient: Spouse / Parent

Group Number: _____ **Group Name:** _____

Specialist Co Pay: _____ **Referral Required: Yes / No**

SECONDARY INSURANCE

Payer Name: _____ **Effective Date:** _____

Insured ID: _____ **Insured Name (if not patient):** _____

Insured DOB (if not patient): _____

Insured Relationship to patient: Spouse / Parent

Group Number: _____ **Group Name:** _____

Specialist Co Pay: _____ **Referral Required: Yes / No**

PATIENT MEDICAL HISTORY QUESTIONAIRE

Glasses wearer: Yes / No **Contact Lens wearer: Yes / No**

Reason for visit/consultation:_____

_____

ALLERGIES

Allergen	Describe Reaction

OCULAR HISTORY

Disease/Problem	Diagnosed When	Treatment	By Whom

SYSTEMIC MEDICAL HISTORY

Disease/Problem	Diagnosed When	Treatment

PATIENT INFORMATION SHEET

If Diabetic: Recent Blood Sugar_____ When_____

FAMILY HISTORY

Family Member	Diagnosis

SOCIAL HISTORY

Do you smoke: yes / no / previously If yes, how long _____

Do you drink Alcohol: yes / no If yes, how much/frequency_____

Do your drink caffeine: yes / no If yes, how much _____

Do you use any recreational drugs: yes / no / formerly

PATIENT INFORMATION SHEET

Please complete this form as thoroughly as possible.

OPHTHALMIC MEDICATION

Medication	Strength	Dosage	Eye	To Treat?

SYSTEMIC MEDICATIONS

Medication	Strength	Dosage	To Treat?

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone: _____ **Pharmacy Fax:** _____

Signature:_____ **Date:**_____

PATIENT INFORMATION SHEET

PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains a Patients Rights section describing your rights under the law. You have the right to review our Notice before signing this consent. The terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operation. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations
- The practice has Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The practice reserves the right to change the Notice of Privacy Practices policy
- The patient has the right to restrict the use of their information but the practice does not have to agree to those restrictions
- The patient may revoke the consent in writing at any time and all future disclosures will then cease
- The practice may condition treatment upon the execution of this consent

This consent was signed by: _____

Signature of Patient or Representative

Relationship to Patient (if other than patient):_____

Date: _____

In front of: _____

Printed Name – Practice Representative

PATIENT INFORMATION SHEET

Release of Insurance Information

I hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare or any private health insurance plan to CORNEAL ASSOCIATES. This assignment is considered valid as original.

X _____

Financial Responsibility

I understand that I am financially responsible for any amount not covered by insurance or any amount deemed the subscriber's responsibility as defined by my insurance company, particularly co-payments, coinsurance and deductibles. Also, I am responsible for anything deemed investigational by my insurance company.

X _____