Treatment Center
An Incorporated Medical Group

NEW PATIENT FORM

NAME_____, _____ ___ BIRTHDATE ___/___/___ AGE_____
(LAST) (FIRST) (MI)

ADDRESS_____ SOCIAL SECURITY# _____-_____-_____

CITY_____ STATE_____ ZIP CODE_____ ( ) MALE ( ) FEMALE

HOME PHONE ( ) _____-_____ CELL PHONE ( ) _____-_____

MARITAL STATUS ( ) SINGLE ( ) MARRIED ( ) DIVORCED ( ) WIDOWED

OCCUPATION_____ WORK PHONE ( ) _____-_____

EMPLOYER_____

ADDRESS_____ STATE_____ ZIP CODE_____

EMERGENCY CONTACT PERSON (Someone NOT living with you)

NAME_____ RELATIONSHIP_____

PHONE ( ) _____-_____ CELL PHONE ( ) _____-_____

MY PROFESSIONAL CHARGES TODAY WILL BE PAID FOR BY:
( ) CASH ( ) CHECK ( ) CREDIT CARD ( ) INSURANCE

PRIMARY INSURANCE COMPANY_____

SUBSCRIBER #_____ GROUP #_____

PRIMARY SUBSCRIBER'S NAME_____ DOB____/____/____

RELATIONSHIP_____ SOCIAL SECURITY # _____-_____-_____

On April 14, 2003, the federal government implemented a new law called the Health Information Portability and Accountability Act (HIPAA). This law and its interpretations, rules, and regulations can be reviewed at the following Internet sites: http://hhs.gov/ocr/hipaa/ or http://www.cms.gov/hipaa/. The computer in our optical department can be used to access these sites.

Our office has always followed the rules as outlined in HIPAA. But a new requirement is that you sign indicating that you understand how your health information may be used and disclosed. To assist you attached for you to keep is a summary document. If you have any questions be sure they are answered before signing below.

In order to keep costs to a minimum we use computerized billing, and send information to Medicare and most insurance companies online. Signing this document also acknowledges that you understand that we may need to furnish them with information about your medical condition. To streamline things we accept assignment from most insurances carriers and Medicare. This means that they will pay us directly and we will refund any overpayment, or bill you for any balance due. If you have not met your deductibles or there is co-pay you will be asked to pay this at the time of your visit. If your account is delinquent after being billed you will be charged interest on the overdue amount at 1 ½ %/month.

If you are being examined for eyeglasses, contact lenses or having a "routine eye examination" these services are usually not covered and you will be required to make a payment for these services at the time of your examination.

Signing this document also means that you understand our billing policies and authorize your insurance carrier or Medicare to pay us directly.

SIGNATURE _____ DATE ____/____/____

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Thank you for choosing us for your eye care needs. We are trying to find out as much as possible about your problem. Please answer the following questions. If there is anything not covered by these questions please add this information. Use the back of the page if necessary.

NAME_____,_____
(LAST) (FIRST)

I AM HERE TODAY BECAUSE_____

I WOULD LIKE THE DOCTOR TO_____

MY PROBLEM STARTED (When?)_____

I WAS REFERRED BY_____

PHONE # ( ) _____-_____

MAJOR ILLNESSES THAT I HAVE/HAD

	ALCOHOLISM		COLITIS		HIV		MIGRAINES
	ANEMIA		DEPRESSION		IMPOTENCE		THYROID
	ASTHMA		DIABETES		KIDNEY		TUBERCULOSIS
	ARTHRITIS		DRUG ABUSE		LIVER		STROKE
	HIGH BLOOD PRESSURE		EPILEPSY		MENTAL ILLNESS		ULCER
	CANCER		HEART				WEIGHT CHANGE
	OTHER						

PAST PROBLEMS WITH MY EYES

	AMBLYOPIA		CROSSED EYES		INJURY		SURGERY
	BLINDNESS		GLAUCOMA		RETINAL PROBLEMS		OTHER
	CATARACT		INFECTIONS		STRABISMUS		

I HAVE A FAMILY MEMBER WITH

	AMBLYOPIA		CROSSED EYES		INJURY		SURGERY
	BLINDNESS		GLAUCOMA		RETINAL PROBLEMS		OTHER
	CATARACT		INFECTIONS		STRABISMUS		

I HAVE HAD MY EYES EXAMINED IN THE PAST BY_____

(*FOR THOSE WHO WEAR GLASSES OR CONTACT LENSES***)**

I AM SATISFIED WITH MY PRESENT GLASSES/CONTACT LENSES? ( ) YES ( ) NO

I HAVE WORN EYEGLASSES SINCE (When?) _____

I HAVE WORN CONTACT LENSES SINCE (When?) _____

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NAME_____,_____
(LAST) (FIRST)

ALLERGIES? ( ) YES ( ) NO
LIST_____
_____

CURRENT MEDICATIONS
_____
_____

CURRENT EYE MEDICATIONS
_____
_____

MY HOBBIES ARE_____

IN ADDITION I USE MY EYES FOR_____

I HAVE SMOKED WITHIN THE PAST 10 YEARS? ( ) YES ( ) NO
I DRINK MORE THAN SIX ALCOHOLIC BEVERAGES A WEEK? ( ) YES ( ) NO

AT PRESENT I HAVE THE FOLLOWING SYMPTOMS/PROBLEMS

	ABNORMAL PUPIL		DOUBLE VISION		NIGHT VISION
	BLIND SPOT(S) IN VISUAL FIELD		DRYNESS		PRESSURE BEHIND EYE(S)
	BLINKING		FLASHING LIGHTS		PRESSURE IN EYE(S)
	BLURRED VISION		FLOATERS		PROTRUSION
	CHANGING VISION		FLUCTUATING VISION		PUFFINESS
	COLOR VISION		HALOS AROUND LIGHTS		RECURRENT INFECTIONS
	CRUSTING EYELID(S)		ITCHING		RED EYE(S)
	DECREASED VISION		JAGGED LINES		RED EYELID(S)
	DEPTH PERCEPTION		LIGHT SENSITIVITY		SPASM
	DISCHARGE		MATTERING		TEARING
	DISCOMFORT		MY FIELD OF VISION		OTHER

THESE SYMPTOMS HAVE BOTHERED ME IN THE PAST

	ABNORMAL PUPIL		EYE TUMOR		LAZY EYE
	BLURRED VISION		FLASHES		LOSS OF VISION
	CATARACT		FLOATERS		OCCUPATIONAL PROBLEMS
	DECREASED VISION		GLAUCOMA		RETINAL DISORDER
	EYE INJURY		IN OR OUT TURNING EYE		SERIOUS EYE INFECTION
	EYE SURGERY		IRITIS OR UVEITIS		OTHER

OTHER INFORMATION TO HELP THE DOCTOR
_____
_____
_____
_____
_____