## PATIENT INFORMATION:

Name: Address: City/State/Zip: Date of Birth: SSN: Email Address: Home telephone: Work: Cell:

Name of Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Consent for patient portal? Yes/No May we leave a message on your phone? Yes/No

Emergency Contact: Telephone #: Pharmacy Name and Location: May we send prescriptions electronically to your pharmacy and import your medications? Yes/No

## INSURANCE INFORMATION:

Primary Insurance Company: Member ID #: Group #:

Policy Holder’s Name: Policy Holder’s DOB:

Secondary Insurance Company: Member ID #: Group #: Policy Holder’s Name: Policy Holder’s DOB:

*I authorize payment of medical benefits to the undersigned physician or supplier for services rendered at time of service. I authorize the release of any information necessary to process this claim. I also request payment of government benefits to the party who accepts assignment. I understand that Rhode Eyeland LLC will not resubmit a claim to an insurance company not disclosed at the time of appointment*.

### I am fully aware that I am responsible for any and all charges not covered by my insurance at today’s visit. This includes, but is not

***limited to:***

* Eye Examination
* Refraction
* Contact Lens Examination
* Any Screenings – including, but not limited to:
  + Visual Acuity, Color Blindness, Amsler Grid, Pupillary Distance
* Any Testing – including, but not limited to:
  + Auto-Refraction, OCT Scanning, Fundus Photography, Visual Field Testing
* Any Procedures or Treatments – including, but not limited to:
  + Corneal Abrasions, Epilation, Punctal Plugs, Foreign Body Removal, Bandage or Therapeutic Contacts
* $50 charge for any missed appointments

Signature: Date:

Relationship to patient: Self Parent Power of Attorney

Initial Here : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **I HAVE** PROVIDED A COPY OF MY INSURANCE CARD

Initial Here : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **I** **HAVE NOT** PROVIDED A COPY OF MY INSURANCE CARD

# Name: DOB: Why do you need an eye exam today? When was your last eye exam? Where? Primary Care Physician: When was your last physical? What medical conditions do you have?

Do you have a history of any eye surgeries? Please list your Medications & any Supplements you are taking:

Are you allergic to any medications, foods, latex, or dyes?  Do you smoke? Non-Smoker Former Smoker Current Smoker

When did you start? When did you quit?

## Please circle all that apply:

Poor Vision Cough Rash/Hives Rapid Heartbeat Eye Pain Congestion Changing Moles Anemia Tearing Wheezing Allergies High Blood Pressure Red Eye Shortness of Breath Hay Fever Bleeding Temporary Vision Loss Headache Arthritis Diabetes Thyroid Abnormalities Fever/Chills Jaw Pain/Scalp Tenderness Joint Pain/Stiffness Stuffy Nose Seizure Upset Stomach Insomnia Ear Ache Stroke Diarrhea Urinary Frequency Weight Loss Paralysis Constipation Burning on Urination Dry Mouth Anxiety/ Depression Incontinence

## Please indicate all that apply:

Allergic to Adhesives or Lidocaine? Yes or No

Using Blood Thinners or Flomax? Yes or No Have a pacemaker, defibrillator, artificial joint or heart valve? Yes or No Have you been exposed to or had Ebola or MRSA? Yes or No

Pregnant or planning to become pregnant? Yes or No

Are you pre-medicating for any upcoming surgeries? Yes or No

Have you received the pneumonia vaccination? Yes or No

Have you received the Influenza Vaccination this year? Yes or No

## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMNT:

I understand that under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy

regarding my protected health information. I understand that this information can and will be used to:

* Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
* I authorize payment of medical benefits to the undersigned physician or supplier for services rendered.
* Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

## PRINTED PATIENT NAME:

**YOUR RELATIONSHIP TO PATIENT:** Self Parent Power of Attorney

## PRINT YOUR NAME (if not patient):

**SIGNATURE: DATE**: