Eye Physicians and Surgeons, P.A.

Please Print **PATIENT REGISTRATION**

Patient's Legal Name: _____ How shall we address you?_____
Street Address:_____ Home Phone:_____
City_____ Cell Phone:_____
State_____Zip_____ Work Phone:_____
Date of Birth : ___/___/____ *Preferred Phone* (circle one:)
Marital Status (circle one) S / M / W Home / Cell / Work
Sex: M_____ F_____ E-mail:_____
Patient's Employer: _____Occupation:_____
Spouse's Name:_____Spouse's Work Phone _____
Spouse's Cell Phone _____Emergency Contact Name and Phone (s):_____

Referring Physician:_____ **Primary Care Physician:**_____
Eye Care Physician:_____ **Specialty Care Physician(s):**_____
Pharmacy:_____ **Location:**_____
Who should we thank for referring you? Name:_____
Reason for Visit:_____

INSURANCE INFORMATION:

Is this condition related to: Employment? (circle one) Y / N Auto Accident? Y / N Other Accident? Y / N
Medicare #: _____
Additional Insurance: Name:_____
Claim Office Address:_____
ID # / Policy #: _____ Group #: _____
Policy Holder's Name: _____ Sex: M_____ F____
Address:_____ Phone #:_____
Relationship of Patient to Policy Holder _____ Date of Birth: ____/____/____
Is Policy Holder's insurance provided by an employer or previous employer? Yes____ No____
Which is primary? (Circle one:) Medicare / Other

Race: (please check one)
☐ American Indian or Alaska Native
☐ Native Hawaiian or Other Pacific Islander
☐ Black or African American
☐ Asian ☐ White

Preferred Language:
☐ English ☐ Portuguese ☐ Japanese
☐ French ☐ Russian ☐ Spanish
☐ Italian ☐ Other _____

Ethnicity: (please check one) ☐ Hispanic ☐ Not Hispanic

I request that payment of authorized medical insurance benefits be made either to me or on my behalf to Eye Physicians & Surgeons, P.A. for any services furnished me by that physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature: _____Date:

TO ALL PATIENTS (INCLUDING MEDICARE PATIENTS):

I understand that the refraction portion of any complete eye examination is not covered for payment by most insurance carriers, including medicare.

Signature: _____Date:_____

Revised 11/2017

PAST OCULAR / MEDICAL HISTORY

ALLERGIES:	REACTION:	SEVERITY (CIRCLE ONE)
		mild / moderate / severe
		mild / moderate / severe
		mild / moderate / severe
		mild / moderate / severe
		mild / moderate / severe
		mild / moderate / severe

PAST OCULAR HISTORY	PAST OCULAR SURGERIES
PAST MEDICAL HISTORY	PAST SURGERIES

FAMILY HISTORY

❑ Diabetes	❑ Stroke	❑ Blindness	❑ Macular Degeneration	❑ Arthritis
❑ Cancer	❑ TB	❑ Cataracts	❑ Retinal Disease	❑ Lazy Eye
❑ Heart Disease	❑ Kidney Disease	❑ Glaucoma	❑ High Blood Pressure	

❑ Other / explanation_____

_____

SOCIAL HISTORY

Smoking: ❑ Yes ❑ No ❑If yes, when started _____When Quit? _____

Alcohol: ❑ Yes ❑ No ❑If yes, how much? _____

Drugs: ❑ Yes ❑ No ❑If yes, drugs used _____

How Much? _____How Long?_____ When Quit?_____

CURRENT OCULAR MEDICATIONS:

Medication	Dosage	Frequency

CURRENT SYSTEMIC MEDICATIONS:

Medication	Dosage	Frequency

REVIEW OF SYTEMS

Eyes

Previous surgery ❑ Yes ❑ No
Contact Lens ❑ Yes ❑ No
Pain ❑ Yes ❑ No
Double Vision ❑ Yes ❑ No
Glaucoma ❑ Yes ❑ No
Cataracts ❑ Yes ❑ No
Macular Degeneration ❑ Yes ❑ No
Dry Eyes ❑ Yes ❑ No
Blurry Vision ❑ Yes ❑ No

Ear, Nose, and Throat

Hard of Hearing ❑ Yes ❑ No
Ringing in Ears ❑ Yes ❑ No
Vertigo ❑ Yes ❑ No

Cardiovascular

Chest Pain ❑ Yes ❑ No
Dizziness ❑ Yes ❑ No
Fainting Spells ❑ Yes ❑ No
Shortness of Breath ❑ Yes ❑ No
Irregular heart Beat ❑ Yes ❑ No
Difficulty Lying Flat ❑ Yes ❑ No

Constitutional

Fatigue Fever ❑ Yes ❑ No
Fever ❑ Yes ❑ No
Previous surgery ❑ Yes ❑ No

Respiratory

Cough ❑ Yes ❑ No
Congestion ❑ Yes ❑ No
Wheezing ❑ Yes ❑ No
Asthma ❑ Yes ❑ No

Gastrointestinal

Heartburn ❑ Yes ❑ No
Nausea/Vomiting ❑ Yes ❑ No
Jaundice/Hepatitis ❑ Yes ❑ No

Genito-Urinary

Pain/Difficulty ❑ Yes ❑ No
Blood in Urine ❑ Yes ❑ No
History of Kidney Stones ❑ Yes ❑ No
History of STD's ❑ Yes ❑ No

Psychiatric

Anxiety/Depression ❑ Yes ❑ No
Mood Swings ❑ Yes ❑ No
Difficulty Sleeping ❑ Yes ❑ No

Endocrine

Increased Thirst ❑ Yes ❑ No
Increased Hunger ❑ Yes ❑ No
Increased Urination ❑ Yes ❑ No
Increased Sweating ❑ Yes ❑ No
Fingernail Changes ❑ Yes ❑ No

Blood/Lymphnodes

Easy Bruising ❑ Yes ❑ No
Gums Bleed Easily ❑ Yes ❑ No
Prolonged Bleeding ❑ Yes ❑ No
Heavy Aspirin Use ❑ Yes ❑ No

MusculoSkeletal

Stiffness ❑ Yes ❑ No
Arthritis ❑ Yes ❑ No
Joint Pain/Swelling ❑ Yes ❑ No

Skin

Rash/Sores ❑ Yes ❑ No
Lesions ❑ Yes ❑ No
Hives/Eczema ❑ Yes ❑ No

Neurological

Seizures ❑ Yes ❑ No
Weakness/Paralysis ❑ Yes ❑ No
Numbness ❑ Yes ❑ No
Tremors ❑ Yes ❑ No

Immunologic

Hives ❑ Yes ❑ No
Itching ❑ Yes ❑ No
Runny Nose ❑ Yes ❑ No
Sinus Pressure ❑ Yes ❑ No

Notes:_____

PATIENT CONSENT FORM

Our Notice of Privacy Practices (September 2013 revision) provides information about how we may use and disclose protected health information about you. The Notice contains a Patient 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 operations. 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, including appointment reminders by postcard, or messages on an answering machine.
- The Practice has a 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 Policies
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this 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 allows the practice to disclose my information to the following people:
Spouse _____ Parents _____
Children _____
Other _____
(Please print the names of the individuals)

_____
Patient or Representative

Relationship to Patient (if other than patient):_____

Date:_____/ /___

In front of _____
Practice representative

DIRECTIONS

From the North via I-95:

1. Take I-95 South to exit 7B (Delaware Avenue – Route 52 North).
2. Make a right turn at the light onto Delaware Avenue.
3. Immediately Delaware Ave. will split. Stay to the left of the split which is Pennsylvania Ave.
4. Follow Pennsylvania Avenue to North Scott Street. There is a 7-11 on the corner. Make a right onto North Scott Street. We are directly behind the 7-11 on the left.

From the South via I-95:

1. Take I-95 North to exit 7 via (Delaware Avenue). You will be on Adams Street. Continue four (4) traffic lights – this will bring you to Delaware Avenue.
2. Make a left onto Delaware Avenue.
3. Continue 2 ½ blocks where Delaware Ave. splits. Stay to the left of the split which is Pennsylvania Ave.
4. Follow Pennsylvania Avenue to North Scott Street. There is a 7-11 on the corner. Make a right onto North Scott Street. We are directly behind the 7-11 on the left.