



# Welcome to Maplewood Eye Care Center

## Patient Registration and Medical History

Today's Date: \_\_\_\_\_

Patient's full Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Name preferred to be called: \_\_\_\_\_ If child, parent's name: \_\_\_\_\_

\*Race: (circle) White Hispanic African American Asian Other Ethnicity: Hispanic Non-Hispanic Unknown

\*Primary Language: English Spanish Non-Verbal Communication Preference: Telephone or Mail

Soc. Sec. # \_\_\_\_\_ Email: \_\_\_\_\_ @ \_\_\_\_\_ Referred by: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home # \_\_\_\_\_ Cell # \_\_\_\_\_  Texting Ok Check One:  Single  Married  Other

Employment:  Full Time  Part Time  Retired  Student  Disabled Occupation: \_\_\_\_\_

If a student:  Full Time  Part Time School Name/ Grade: \_\_\_\_\_

Employer's Name \_\_\_\_\_ Business Phone: \_\_\_\_\_

**A Refraction (the measurement of your eye's needed for an eyeglass prescription)** is typically not a covered benefit of insurance plans. The **fee for the refraction is \$34.00 and is performed during your complete/yearly exam.** We will submit this service to your insurance, however most insurance have limitations for this service.

**You will be financially responsible for your account:** For professional services, if your insurance bill exceeds \$100, we will gladly file your insurance. You will be responsible for paying the co-payment at the time of your visit. You will receive a copy of your itemized charges so that you may file with your insurance. For optical services, ordering prescription eyewear / contact lenses requires a minimum 50% deposit at the time of ordering with the balance due in full at the time of dispensing.

**Signature on File:** We are required to obtain your signature so that standard, required insurance forms may be completed properly. Please provide your signature in the space below. 1) I authorize use of this form on all my insurance submissions. 2) I authorize release of information to my insurance carrier. 3) I understand that if my insurance does not pay, I will be responsible for the services rendered. 4) I authorize payment to my doctor. 5) A copy of this authorization may be used in place of the original.

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_

### HIPPA

By signing here, I am consenting to allow Maplewood EyeCare Center to use and disclose my PHI to the name (s) listed below:

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

I acknowledge that I have read/received a copy of Maplewood EyeCare Center's Notice of Privacy Practices.

Patient Name: \_\_\_\_\_ Signature : \_\_\_\_\_

### MEDICAL HISTORY

The following information is essential for this office to provide eye care in a manner that is compatible with your general health. Your cooperation in providing accurate information is necessary to meet your eye health and vision needs safely and efficiently. Incorrect information can be dangerous to your health. Your answers are for your medical records only and will remain CONFIDENTIAL. Thank you for your assistance.

Name of your primary care physician: \_\_\_\_\_ Phone \_\_\_\_\_

Name of your pharmacy: \_\_\_\_\_

\* "Meaningful Use (MU)" is a government program to ensure that healthcare professionals are utilizing their Electronic medical Record (EMR) system efficiently to improve healthcare quality. A core MU is to record patient demographics.

Please list **all** medications taken (including birth control, eye drops, OTC medications, herbs vitamins etc.):

**Are you currently under the care of a physician?**  Yes  No If yes, what is the reason or condition?

List **all** medications that **you are allergic to** or cannot take: \_\_\_\_\_

### PERSONAL EYE INFORMATION

Is there a family history of cataract, glaucoma, macular degeneration or other eye condition? \_\_\_\_\_

Have you had any eye surgeries, injuries or serious conditions? Yes or No. If yes, please describe: \_\_\_\_\_

**When was your last eye exam?** \_\_\_\_\_ . **Where glasses prescribed:** Yes or No

**CONTACT LENS EXAM:** Are we providing contact lens services today? **Yes or No.** If yes **PAYMENT IS DUE AT THE TIME OF SERVICE.** Contact lens service, initial fitting, refitting etc., are not part of a complete exam and represent additional out of pocket expenses. If you have any questions, please inquire about fees before services are rendered. These fees apply to all contact lens exam patients.

### CONTACT LENS HISTORY:

**Do you wear contacts?** YES or NO **How many years?** \_\_\_\_\_ **Type of Solution:** \_\_\_\_\_  
**Brand of Contacts:** \_\_\_\_\_ **Type:** Soft or RGP **Age of current lenses:** \_\_\_\_\_  
**Number of hours/days:** \_\_\_\_\_ **Do you sleep in contacts?** Yes/No  
**How often do you replace your contacts?** Daily 2 weeks Monthly Yearly I wear them until they bother me

### PLEASE PLACE A CHECK MARK (✓) BY ANY OF THE FOLLOWING HEALTH CONDITIONS BELOW THAT APPLY TO YOU:

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Allergies to drugs     | <input type="checkbox"/> Eyelid /eyelash crusting | <input type="checkbox"/> Head Injury    | <input type="checkbox"/> Arthritis                  |
| <input type="checkbox"/> Headaches              | <input type="checkbox"/> Sun /glare sensitivity   | <input type="checkbox"/> HIV/AIDS       | <input type="checkbox"/> Kidney trouble             |
| <input type="checkbox"/> Fluctuating vision     | <input type="checkbox"/> Floaters or Flashes      | <input type="checkbox"/> Hepatitis B    | <input type="checkbox"/> Thyroid disease            |
| <input type="checkbox"/> Decreased Vision       | <input type="checkbox"/> Glaucoma                 | <input type="checkbox"/> Hepatitis C    | <input type="checkbox"/> Hay fever or sinus trouble |
| <input type="checkbox"/> Double vision          | <input type="checkbox"/> Low blood pressure       | <input type="checkbox"/> Bipolar / ADHD | <input type="checkbox"/> Jaundice, hepatitis        |
| <input type="checkbox"/> Watery eyes            | <input type="checkbox"/> High blood pressure      | <input type="checkbox"/> Lung disease   | <input type="checkbox"/> Liver disease              |
| <input type="checkbox"/> Eye / eyelid redness   | <input type="checkbox"/> Heart disease            | <input type="checkbox"/> Asthma         | <input type="checkbox"/> Blood disorder/            |
| <input type="checkbox"/> Eye / eyelid dryness   | <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Seizures       | <input type="checkbox"/> Anemia                     |
| <input type="checkbox"/> Eye / eyelid itching   | <input type="checkbox"/> Sugar level _____        | <input type="checkbox"/> Head trauma    | <input type="checkbox"/> Disability? Type? _____    |
| <input type="checkbox"/> Eye / eyelid pain      | <input type="checkbox"/> A1C _____                | <input type="checkbox"/> Stroke         |   |
| <input type="checkbox"/> Eye / eyelid discharge | <input type="checkbox"/> High Cholesterol         | <input type="checkbox"/> Depression     |   |

### Social History

Do you smoke? Yes / No How Long? \_\_\_\_\_ How Many packs per day? \_\_\_\_\_  
Are you a: Current Every day Smoker Light Smoker (1-9 cig/day) Heavy Smoker (10 or more cig/day)  
Are you a former smoker? YES or NO How Long? \_\_\_\_\_ Narcotic Use? None Chemical Recreational  
Do you drink alcohol? YES or NO How Long? \_\_\_\_\_  
How often? Social Only 1-2 daily Above average

Thank you for your assistance