INVISION
Family Eyecare

Registration form

Patient Information

First Name: _____ Last Name: _____ Middle Name: _____ Home Address: _____

City: _____ State: _____ Zip Code: _____ Date of Birth: _____

Gender
- ○ Male
- ○ Female

Age: _____ SSN (last 4 digit) _____ Preferred Language: _____

Contact Information

Cell Phone: _____ Home Phone: _____ Work Number: _____ Email: _____

Emergency Contact Information

Name: _____ Relationship: _____ Phone: _____

What brings you to our office today?

Please check all that apply

Select
- ☐ Routine Eye Exam
- ☐ Want Contact Lenses

Select
- ☐ Want Glasses
- ☐ Other:

Other _____

Select
- ☐ Double Vision
- ☐ Eye Infection
- ☐ Eye Strain

Select
- ☐ Tearing
- ☐ Burning Eye(s)
- ☐ Red Eye

Select
- ☐ Flashes/Floaters
- ☐ Headaches
- ☐ Glare

Medical & Vision Insurance

Medical Insurance _____ Do you have medical insurance?
- ○ Yes
- ○ No

Provider Name: _____

Insured's Name: _____ Insured's Date of Birth: _____ Relationship: _____ Member ID: _____ Group Number: _____ Insured's Employer: _____

Vision Insurance:

Do you have vision Insurance?
- ○ Yes
- ○ No

Provider _____ Insured's Name: _____ Insured's Date of Birth: _____ Relationship: _____

Member ID: _____ Group Number: _____ Insured's Employer: _____ Patient/Guardian Signature: Sign _____ Date: _____

Medical History

Primary Care Physician: _____ Phone: _____ Preferred Pharmacy: _____ Phone: _____

Do you have or have you ever had any of the following conditions: .

Other Condition/Illness:

- ☐ Arthritis
- ☐ Asthma/COPD
- ☐ Cancer
- ☐ Chronic fever
- ☐ Diabetes
- ☐ Pre - Diabetes
- ☐ Gastrointestinal Conditions
- ☐ Endocrine Conditions
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Pregnant/Nursing
- ☐ Seasonal Allergies
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ None

List any previous major injuries/surgeries/hospitalizations:

Are you allergic to any medications?

List any medications you are now taking (including eye drops, birth control pills, vitamins or over the counter medications):

Smoking History
- ☐ Current Every Day Smoker
- ☐ Current Some Day Smoker
- ☐ Former Smoker
- ☐ Never Smoker

Do you drink alcohol?
- ☐ Yes
- ☐ No

Do you use illegal drugs?
- ☐ Yes
- ☐ No

Eye History:

Last eyecare provider:

Date of last eye exam:

Are you currently having eye or vision problems?
- ☐ Yes
- ☐ No

If yes, please explain:

Do you wear glasses?
- ☐ Yes
- ☐ No

How old are they?

Are they bifocals?
- ☐ Yes
- ☐ No

Are they for
- ☐ Reading
- ☐ Distance
- ☐ Both

Have you ever worn contact lenses?
- ☐ Yes
- ☐ No

If yes, when were they prescribed?

Do you wear contacts now?
- ☐ Yes
- ☐ No

If not, why did you quit?

Are you interested in wearing contact lenses?
- ☐ Yes
- ☐ No

When was the last time you had your eyelids cleaned?
- ☐ Yes
- ☐ No

Do you have or have you ever had any of the following conditions:
- ☐ Blurred Vision
- ☐ Cataracts
- ☐ Double Vision
- ☐ Dry Eye
- ☐ Eye Injury
- ☐ Eye Surgery or LASIK
- ☐ Flashes

.
- ☐ Floaters
- ☐ Glaucoma
- ☐ Lazy/Crossed Eye
- ☐ Loss of Vision
- ☐ Macular Degeneration
- ☐ Migraine/Headache
- ☐ Retinal Detachment

Family History (Please use the checkboxes to indicate who in your family has/had the condition)

	Parent	Sibling	Child
Blindness	☐	☐	☐
Cataract	☐	☐	☐
Diabetes	☐	☐	☐
Glaucoma	☐	☐	☐
High Blood Pressure	☐	☐	☐
Lazy/Crossed Eye	☐	☐	☐
Macular Degeneration	☐	☐	☐
Retinal Detachment	☐	☐	☐

Other Eye Disease or Condition:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the doctor of any changes in medical status.

Patient/Guardian Signature:

Sign

Date

Consent for Use and Disclosure of Protected Health Information

SECTION A: PATIENT GIVING CONSENT

Initial Acknowledgment of Privacy Practices

☐ I agree

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent:

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices:

You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: _____ Telephone: _____ Fax: _____ E-mail: _____

I have had full opportunity to read and consider the contents of this consent form and your notice of privacy practices. I understand that, by signing this consent form, I give my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Signature:

Sign

☐ I agree

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____ Relationship to Patient: _____

Stop. ONLY complete Section C if you do not Consent.

SECTION C: RIGHT TO REVOKE: Please read carefully before signing

Right to Revoke:

You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Signature:

Sign

If this Revoke of Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____ Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the patient's chart.