EYEDOCDULLES

Dr. Joanna M Barnett & Associates Inc

PATIENT'S NAME: LAST FIRST MIDDLE	**DATE OF BIRTH:** SSN# __/__/__ ___-___-___
HOME/MAILING ADDRESS: CITY	STATE ZIP CODE
GENDER (PLEASE CIRCLE ONE): *FEMALE MALE*	**CELL PHONE NUMBER:**
OCCUPATION:	**BEST WAY TO CONTACT YOU (PLEASE CHECK ONE):** O PHONE O EMAIL
HOW WERE YOU REFERRED TO US? (PLEASE CHECK ONE): O *SOCIAL MEDIA* O *FRIEND/FAMILY* O *OTHER*_____	**NAME OF YOUR PRIMARY CARE PHYSICIAN:**
MINOR'S LEGAL GUARDIAN: NAME: DOB: __/__/__ SSN#: ___-___-___	**MINOR'S LEGAL GUARDIAN:** NAME: DOB: __/__/__ SSN#: ___-___-___
MARITAL STATUS (PLEASE CIRCLE ONE): *SINGLE MARRIED SEPARATED DIVORCED WIDOWED*	**EMAIL ADDRESS:**_____
VISION INSURANCE	**MEDICAL INSURANCE**
NAME OF POLICY HOLDER: LAST FIRST MIDDLE **DATE OF BIRTH:** **GENDER (PLEASE CIRCLE)** __/__/__ ***FEMALE MALE*** **RELATIONSHIP WITH PATIENT:**	**NAME OF POLICY HOLDER:** LAST FIRST MIDDLE **DATE OF BIRTH:** **GENDER (PLEASE CIRCLE)** __/__/__ ***FEMALE MALE*** **RELATIONSHIP WITH PATIENT:**
NAME OF *VISION* INSURANCE: POLICY ID: GROUP#:	**NAME OF *MEDICAL* INSURANCE:** POLICY ID: GROUP#:
HOME/MAILING ADDRESS OF *POLICY HOLDER*:	**HOME/MAILING ADDRESS OF *POLICY HOLDER*:**
HOME PHONE NUMBER OF POLICY HOLDER:	**HOME PHONE NUMBER OF POLICY HOLDER:**
EMPLOYER OF *POLICY HOLDER:*	**EMPLOYER OF *POLICY HOLDER:***

The undersigned patient or individual acting on behalf of the patient agrees as follows:

1. Authority is granted to EYEDOCDULLES to render needed treatment to the above named.
2. Permission is granted to EYEDOCDULLES to release information regarding medical treatment, rendered to the above named patient to any insurance company, employer or referring physician.
3. **Managed Health Care Plans**: I understand that if I do not have vision coverage, or I am not eligible for a vision exam, I am responsible for a referral from my primary care physician. I understand that medical exams without a referral are my financial responsibility.
4. **I understand that it is my responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by my insurance company.**
5. I understand that a charge of **$75.00** may be issued if I do not **cancel or make changes** to my appointment **24-48 hrs** prior to my appointment.

_____ __/__/__ _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN **Date** **FRONT DESK/ WITNESS SIGNATURE**

REVIEW OF SYSTEMS Do you currently have any of the following problems? If YES, please explain below			
• Please list any medication that you are taking, including eye drops.	☐ Yes ☐ No		• Glaucoma: ☐ Yes ☐ No • Do you smoke? ☐ Yes ☐ No If yes, how much? _____ • Diabetes: ☐ Yes ☐ No • Drink Alcohol? ☐ Yes ☐ No If yes, how much? _____ • High blood pressure: ☐ Yes ☐ No • Macular Degeneration: ☐ Yes ☐ No • Other _____
• Do you have any allergies to any medications?	☐ Yes ☐ No		
• Constitutional (Fever, weight loss, other)	☐ Yes ☐ No		
• Eyes (Glaucoma, Cataract, Lazy eyes, Retina problems, Sore throat)	☐ Yes ☐ No		
• Ear/ nose/ throat (hearing loss, sinus problems, sore throat)	☐ Yes ☐ No		
• Cardiovascular (heart problems, chest pain, irregular heart beat)	☐ Yes ☐ No		
• Respiratory (Asthma, Shortness of breath, Wheezing, Coughing)	☐ Yes ☐ No		
• Gastrointestinal (Heartburn, Abdomen Pain, Diarrhea, Vomiting)	☐ Yes ☐ No		
• Genitourinary (Urinary problems, Blood in urine)	☐ Yes ☐ No		
• Integumentary (Skin rashes, excessive dryness)	☐ Yes ☐ No		
• Musculoskeletal (muscle aches, joint pain, swollen joints)	☐ Yes ☐ No		
• Neurological (numbness, weakness, headaches, paralysis)	☐ Yes ☐ No		
• Hematological/ Lymphatic (blood disorders, Leukemia)	☐ Yes ☐ No		
• Allergic/Immunologic (hay fever, allergies)	☐ Yes ☐ No		
• Endocrine (thyroid problems)	☐ Yes ☐ No		
• Psychiatric (depression, anxiety)	☐ Yes ☐ No		

HIPAA PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to Privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessment and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this practice has the right to change this notice from time to time, and that I may contact the practice at any time to obtain a current copy.

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 my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

The type of PHI to be restricted or limited: _____

I give permission to discuss my medical care with the following individuals: _____

I understand that I may revoke this consent in writing at any time, except to the extent that you have take action relying on this consent.

Patient's Name: _____ **Signature of Patient/Legal Guardian:** _____

Relationship to Patient: _____ **Date:** _____/_____/_____