FAMILY EYE CARE

11/6/18

Confidential Patient Health Record

Personal History

Name:________________ Address:________________ PO________

City:________________ State:________________ Zip:________

Social Sec. #:________________ Birth Date:________ Age____ Sex: ☐ M ☐ F

Driver's License #________________ Race (optional): (Am. Indian) (Asian) (African Am.) (Nat. HI) (White)

Ethnicity: Hispanic or Latino: ☐ Y ☐ N

Home Phone:________________ Work Phone:________________ Cell Phone:________________

Do you want your information shared with ☐ spouse ☐ children ☐ other ________________

Employer________________ Type of Work:________________

Circle One: Single Married Widowed Divorced Separated Name Of Spouse:________________

Spouse's Employer:________________ Spouse's Social Sec#________________

Names and Ages of Children @ home:________________

Referred to This Office By:________________

Name and Relationship of Emergency Contact:________________

Address:________________ **Phone #:** ________________

Current Health History:

Family Doctor:________________ City:________________ Phone Number:________________

Pharmacy of Choice: ________________ City: ________________ Phone Number: ________________

Family History:

☐ Glaucoma (Mom) (Dad) (Bro.) (Sis.) (Son) (Daughter)

☐ Cataracts (Mom) (Dad) (Bro.) (Sis.) (Son) (Daughter)

☐ Macular Degeneration (Mom) (Dad) (Bro.) (Sis.) (Son) (Dtr)

☐ High Blood Pressure (Mom) (Dad) (Bro.) (Sis.) (Son) (Daughter)

☐ Diabetes (Mom) (Dad) (Bro.) (Sis.) (Son) (Daughter)

Ocular History: (Please list any eye medications)

Last Eye Exam: ________________

☐ Glaucoma: Last Checked: ________________

☐ Cataract: Last Checked: ________________

☐ Macular Degeneration: Last Checked: ________________

☐ Cataract Surgery: Surgeon's Name: ________________ ☐ Right ☐ Left

☐ Inflammatory Disorders Last Checked: ________________

☐ Blurred Vision ☐ Near ☐ Distance ☐ Everything

☐ Double Vision

☐ Other ________________

☐ Diabetic Eye Disease: Last Checked: ________________

☐ Iritis: Last Checked: ________________

☐ Eye Trauma: Last Checked: ________________

☐ Retinal Detachment: Last Checked: ________________

☐ Refractive Surgery: Type: ________________ Date of Surgery: ________________ ☐ Right ☐ Left

I understand and agree that vision, health, and accident insurance is an arrangement between an insurance carrier and myself. Furthermore, I understand that Family Eye Care will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Family Eye Care will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate treatment any fees for professional services or materials will be immediately due and payable.

I hereby authorize Family Eye Care and any Doctors working on its behalf to treat my conditions as deemed appropriate. Information collected will be handled as described in *Notice of Privacy Practices* statement dated April 14, 2003, modified September 18, 2013. Restrictions to handling of your PHI may be requested. Family Eye Care will not be responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis. You may revoke consent to handle your PHI in writing except to the extent of action already taken in reliance to consent Questions should be addressed to the Receptionist or Dr. Jenkins.

I authorize Family Eye Care to correspond written or verbally with pharmacies or other health care providers on my behalf.

*Signature*________________ *(Patient) (Parent) (Guardian) Date*________________

If Parent or Guardian please print name: ________________

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Please put a check next to all that apply and list any medication next to what it applies to. Date ____________________

Constitutional	Ears, Nose, Mouth & Throat	Neurological
☐ developmental disability ☐ cancer ☐ fatigue syndrome ☐ other Height: ______________ Weight: ______________	☐ hearing loss ☐ sinusitis ☐ dry mouth ☐ laryngitis ☐ other	☐ multiple sclerosis ☐ epilepsy ☐ cerebral palsy ☐ tumor ☐ stroke/cva ☐ migraine ☐ autism spectrum disorder ☐ other
Psychiatric	**Cardiovascular**	**Respiratory**
☐ depression ☐ attention deficit ☐ anxiety disorder ☐ bipolar disorder ☐ other	☐ high blood pressure ☐ stroke/cva ☐ heart disease ☐ vascular disease ☐ congestive heart failure ☐ other Last blood pressure ______/______	☐ tobacco use: cigarette ___ cigar ____ chew ____ never ____ former ____current ___ ☐ asthma ☐ bronchitis ☐ emphysema ☐ chronic obstruction ☐ sleep apnea ☐ other
Gastrointestinal	**Genitourinary**	**Musculoskeletal**
☐ Crohn's ☐ colitis ☐ ulcer ☐ acid reflux ☐ celiac disease ☐ other	☐ kidney disease ☐ prostate disease/cancer ☐ STD - herpetic, chlamydia ☐ venign prostate hypertrophy ☐ herpes ☐ chlamydia ☐ other	☐ osteoarthritis ☐ arthritis ☐ fibromyalgia ☐ muscular dystrophy ☐ ankylosing spondylitis ☐ osteoporosis ☐ gout ☐ other
Integumentary	**Endocrine**	**Hematologic/Lymphatic**
☐ eczema ☐ rosacea ☐ psoriasis ☐ herpes simplex/cold sores ☐ herpes zoster/shingles ☐ other	☐ type 2 diabetes mellitus ☐ type 1 diabetes mellitus Last Blood Sugar & A1C __________ Treating Dr.: ___________________ ☐ thyroid dysfunction ☐ hormonal dysfunction ☐ other	☐ anemia ☐ large volume blood loss ☐ ulcer ☐ high cholesterol ☐ other
Allergic/Immunologic	**Other Medications** (include OTC medications & eye drops):	**Hobbies/Work Activities**
☐ drug allergy ☐ environmental allergy ☐ rheumatoid arthritis ☐ lupus ☐ sjogren's syndrome ☐ latex sensitivity ☐ other Drug allergies:	___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________	☐ Computer ☐ Reading ☐ Golf ☐ Hunting ☐ Fishing ☐ Skiing ☐ Video Games ☐ Watch TV ☐ Other _________________________

Email address:____ I authorize Family Eye Care, PC, to use my email for appointment reminders and to notify me of eye wear being ready. ☐ Yes ☐ No

FAMILY EYE CARE

INSURANCE ASSIGNMENT POLICY

Our office is pleased to accept your insurance assignment. We offer this service as a courtesy to our patients. However, it must be clearly understood that the "contract" is between you, the patient, and your insurance company. You are thereby responsible for your account and any amount not paid by your insurance company.

Following is a statement of our policies governing insurance claims:

1. Although our office will bill your insurance company, it is necessary for the patient to provide all of the insurance information.
2. We require our patients to sign an "Authorization to Pay The Doctor" form (or any other necessary assignment documents required by your insurance company). By doing so, the insurance company will make payment directly to our office.
3. The patient will pay the deductible and/or co-payment (the amount not covered by the insurance company).
4. Insurance payments ordinarily are received within 30 to 60 days from the time of billing. If a patient's insurance company has not made payment to our office within 90 days, we may request the patient to pay the balance due, and then seek reimbursement from the insurance company when and if it pays.
5. Family Eye Care does NOT guarantee that the patient's insurance company will pay. We will perform our routine insurance billing procedures upon verification of coverage. However, if for some reason, the patient's insurance claim is denied, the patient is then considered to be responsible for the full amount of the bill.
6. Our office will not enter into a "dispute" with an insurance company over any claim, although we will work with the insurance company to sort out any confusions or questions that might arise. We cooperate fully with the regulations and requests of the insurance companies. It will be, however, the responsibility of the patient to handle with the insurance company any type of dispute over payment by the company.
7. I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by or in Family Eye Care. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.
8. I have the right to restrict disclosure of my PHI to my health plan at which time I would be responsible to pay out of pocket for all services and materials that would normally be covered by my health plan.
9. If you have any medical diagnosis it must be billed to your primary medical insurance and you will be responsible for any deductible or copay that applies on your policy, if your vision insurance allows for coordinating benefits we will bill the vision policy.

Who is Responsible for Your Bill, You and ☐ Spouse ☐ Worker's Comp ☐ Auto insurance ☐ Medicare

☐ Health Insurance (Name)________________________ Health Card #_________________________

☐ Health Insurance (Name)________________________ Health Card #_________________________

☐ Vision Care Insurance Rider______________________ Insured Person's Name_________________

DOB of Primary Insured: __________________

IF YOU UNDERSTAND AND AGREE WITH ALL OF THE ABOVE OFFICE POLICIES, PLEASE SIGN YOUR NAME BELOW AND WE WILL ACCEPT YOUR INSURANCE ASSIGNMENT.

*Signature*____ *(Patient) (Parent) (Guardian) Date*__________________

If Parent or Guardian please print name: ____