PATIENT REGISTRATION

Name:_____ Date of Birth:_____ Age:_____

SS#:_____ Sex:_____ Marital Status:_____

Race:_____ Ethnicity:_____ Height:___ft ___ in Weight:_____ lbs

Family Physician:_____

Mailing Address:_____ City/State/Zip:_____

Physical Address:_____ City/State/Zip:_____
(If different that Mailing)

Home Phone:_____ Cell Phone:_____ Texting ok: Y or N

Employer:_____ Occupation:_____ Work Phone:_____

Preferred Language:_____ Preferred Method of Communication:_____
(English, Spanish, etc.) (Home Phone, Cell Phone, Email, etc)

Email Address:_____ Whom may we thank for referring you?:_____

Emergency Contact:_____ Phone:_____
(Emergency Contact should be a relative, friend, or neighbor that does not reside with you)

PLEASE PROVIDE THE OFFICE WITH A COPY OF YOUR INSURANCE CARD(s), BOTH MEDICAL & VISION.

Insurance Co: _____ ID#:_____
Group #:_____ Does this Policy have Vision?:_____
Subscriber's Name:_____ Subscriber's Date of Birth:_____
Subscriber's Address:_____ City/State/Zip:_____
Subscriber's SS#:_____

IF CHILD Father's Name:_____ Phone:_____
Business Address:_____ Employer: _____
Mother's Name:_____ Phone:_____
Business Address:_____ Employer:_____

ASSIGNMENT AND RELEASE

I hereby authorize the physician to release any information required to process this claim. I also authorize my insurance benefits be paid directly to the physician, and I understand I am financially responsible for non- covered services.

Signature of patient or parent if minor: **X:**_____ **Date:**_____

WYTHE EYE ASSOCIATES **MEDICAL HISTORY QUESTIONNAIRE**

GENERAL PATIENT INFORMATION

Name_____ Today's Date:_____

Primary Care Physician:_____ Preferred Pharmacy:_____

EYE HISTORY

Last eye examination:_____ years ago. Where?_____

Do you currently wear glasses? Y/N If yes, how old are they?_____ For how many years?_____

Do you currently wear contacts? Y/N If no, are you interested in being fitted with contacts? Y/N

Have you ever had any eye surgery? Y/N If yes, what?_____

Do you currently, or have you ever experienced any following problems:

Blurred / Distorted Vision	__ no	__ yes	
Double Vision	__ no	__ yes	
Blackout or Temporally loss of vision	__ no	__ yes	
Sever or Frequent Headaches	__ no	__ yes	
Itching / Burning / Stinging eye	__ no	__ yes	
Sandy / Gritty / Foreign body sensations	__ no	__ yes	
Flashes of light and/or Floaters	__ no	__ yes	
Eye infection	__ no	__ yes	if yes, what?_____
Eye injury	__ no	__ yes	if yes, how?_____
Cataract	__ no	__ yes	if yes, surgery?_____

Other:_____

SOCIAL HISTORY

Do you smoke? Y/N # of packs per day?_____ Do you drink alcohol? Y/N # of drinks per day? _____

Do you use illegal drugs? Y/N What type?_____

Have you ever been exposed to or infected with: __ HIV __ Hepatitis __ Syphilis __ Gonorrhea __ None

Do you use a computer? Y/N If yes, how many hours/day?_____

Hobbies:_____

MEDICAL HISTORY

List any medications (including oral contraceptives, aspirin, and other over the counter medication):_____

_____

_____

List any allergies (including medication, foods, seasonal, etc):_____

Do you or any of your blood relatives have any of the following health problems in the following areas:

Diabetes	__ no	__ self	__ family, relationship_____
High Blood Pressure	__ *no*	__ *self*	__ *family, relationship*_____
Heart Disease	__ no	__ self	__ family, relationship_____
Cancer	__ no	__ self	__ family, relationship_____
Lupus	__ no	__ self	__ family, relationship_____
Arthritis	__ no	__ self	__ family, relationship_____
Thyroid disease	__ no	__ self	__ family, relationship_____
Glaucoma	__ no	__ self	__ family, relationship_____
Lazy, Crossed eye	__ no	__ self	__ family, relationship_____
Macular Degeneration	__ no	__ self	__ family, relationship_____
Blindness	__ no	__ self	__ family, relationship_____
Weight Loss/Gain	__ no	__ self	If yes, explain_____
Lung Problem	__ no	__ self	If yes, explain_____
Allergy	__ no	__ self	If yes, explain_____
Neurological	__ no	__ self	If yes, explain_____
Psychological	__ no	__ self	If yes, explain_____

Other_____

NOTICE OF PRIVACY PRACTICES

In order to protect privacy and confidentiality of your health information, Wythe Eye Associates and their staff members are requesting your permission to provide information to individuals other than yourself.

Please identify individuals that you agree to allow Wythe Eye Associates and their staff members to communicate healthcare and billing information to via telephone, fax, or in person.

NAME:_____ **RELASTIONSHIP:**_____

NAME:_____ **RELATIONSHIP:**_____

NAME:_____ **RELATIONSHIP:**_____

I AGREE that information directly related to my healthcare and billing can be released to family members, relatives, close personal friends, or any other person that I identified above.

I AGREE to be contacted by telephone, mail, or e-mail for appointment conformations, follow-up, about treatments or test results, in an emergency at work, and that you may leave messages on my answering machine.

I acknowledge that I have received a copy of Wythe Eye Associates Notice of Privacy Practices, which describes how my medical information is used, disclosed, and how I may access this information. I hereby authorize the physician to release any information required to process my insurance claim. I also authorize my insurance benefits be paid directly to the physician, and I understand that I am responsible for any non-covered services or goods.

PATIENT'S PRINTED NAME:_____

PATIENT'S SIGNATURE:_____ **DATE:**_____

Relationship to patient, if signed by anyone other than the patient. (Parent/Legal Guardian, personal representative, etc.) _____

If you have any questions or concerns about when and how your information is being used or any reports about possible violations in this office, feel free to contact Julie Burton (HIPPA COMPLIANCE OFFICER) (276) 223-0033.