WASHINGTON
EYE
PHYSICIANS & SURGEONS

PATIENT REGISTRATION FORM

Date: ______________________________

Name: ____ Birthdate: ______________
MR / MRS / MS / MISS   LAST   FIRST   M.I.

Your Relationship to Insured: ❑ Self ❑ Spouse ❑ Dep ❑ Other ______________________ Sex: ________

Address: ____
STREET   APT. #   CITY   STATE   ZIP CODE

Home Ph. ( ) ______________________ Work Ph. ( ) ______________________

Cell Ph. ( ) ______________________ Preferred Contact: ❑ Home ❑ Cell ❑ Work

E-mail: ____

Language: ______________ Race: ______________ Ethnicity: ______________

Emergency Contact and # ____

Occupation: ______________ Who referred you to our office: ______________________

Was referral by a physician? ❑ Yes ❑ No If yes, please provide referring physician's name and address:

____
LAST   FIRST   CITY   STATE

ABOUT YOUR VISION

Are you interested in receiving information about laser vision correction for improving your vision without glasses or contacts?

❑ Yes ❑ No

Do You Wear Contact Lenses?

❑ Yes ❑ No

Do You Sleep in Your Contact Lenses?

❑ Yes ❑ No

Do You Wear Glasses?

❑ Yes ❑ No

Age of Present Glasses: ________

When do you wear glasses or contacts?

- ❑ Reading
- ❑ Distance
- ❑ Computers
- ❑ Sports
- ❑ Playing Musical Instruments
- ❑ Other: ______________________________

____

Who is your current eye doctor? ______________________

____

Turn over and fill out back

INSURANCE INFORMATION

Primary

Insurance Co.: ______________________________

____

Policy #: ______________________________

Group # ______________ Plan # ______________

Name of Policy Holder: ______________________________

Date of Birth of Policy Holder: ______________________________

Copay: ______________________________

Deductible: ______________________________

Secondary

Insurance Co.: ______________________________

____

Policy #: ______________________________

Group # ______________ Plan # ______________

Name of Policy Holder: ______________________________

Date of Birth of Policy Holder: ______________________________

Copay: ______________________________

Deductible: ______________________________

Use and Disclosure of Protected Health Information

PATIENT ACKNOWLEDGEMENT & CONSENT FORM

Acknowledgement of Notification

Washington Eye Physicians & Surgeons' **Notice of Privacy Practices** provides information about how our practice might use and disclose protected health information about you, and is compliant with the requirements of the Health Insurance Portability Act of 1996 (HIPAA).

Our **Notice of Privacy Practices** states that we reserve the right to change the terms described. Should this happen, a notice will be prominently posted in our offices.

You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care operations. We are not required to agree to your restrictions; but if we do, we are bound by our agreement with you.

By signing below, you acknowledge receipt of our ***Notice of Privacy Practices****.*

____

Patient's Signature Print Full Name Date

Consent for Use and Disclosure of Information

By signing below, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in trust on your prior consent.

I request that payment of authorized Medicare/Insurance carrier benefits be made on my behalf to Washington Eye Physicians & Surgeons, PC for any services furnished to me by that physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare/Medicaid Services and its agent and/or any other Insurance Carriers for which I have coverage, any information needed to determine these benefits or the benefits payable for related services. I agree to provide all referral and treatment plan(s) as required by my insurance carrier(s). All co-pays must be paid at the time of service in accordance with the contracted Insurance Carrier Agreements.

____

Patient's Signature Print Full Name Date

FOR MORE INFORMATION OR TO REPORT A PROBLEM: If you have questions or would like additional information, please contact the HIPAA Policy Officer for this practice. If you believe your privacy rights have been violated, you may file a written complaint with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

MEDICAL HISTORY QUESTIONNAIRE

Name:____ Date of Birth: ____/____/______

Race: ❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American
❑ Native Hawaiian or Other Pacific Islander ❑ White

Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino

Preferred Language: ❑ English ❑ French ❑ Spanish ❑ Russian ❑ Italian ❑ Other ____________________

HEALTHCARE PROVIDER INFORMATION:

Primary Care Physician: ____ Phone #: ______________________

Pharmacy Name and Location (street & city):____

Drug Allergies:	Reaction	Severity
_______________________	________________________	mild / moderate / severe
_______________________	________________________	mild / moderate / severe
_______________________	________________________	mild / moderate / severe

Past Ocular History: (Please mark all that apply) ❑ No history of eye problems

❑ Amblyopia (Lazy Eye)
❑ Astigmatism
❑ Cataracts
❑ Corneal Disorder
❑ Diabetic Retinopathy
❑ Dry Eye Syndrome
❑ Glaucoma
❑ Hyperopia (Farsighted)
❑ Iritis/Uveitis
❑ Macular Degeneration
❑ Myopia (Nearsighted)
❑ Narrow Angle Glaucoma
❑ Retinal Detachment

Other ____

Ocular Surgeries: (Please mark all that apply) ❑ No prior ocular surgery

R - L
❑ Blepharoplasty (Lid Surgery)
❑ Cataract Surgery
❑ Corneal Transplant

R - L
❑ Glaucoma Surgery or Laser
❑ Laser Retinal Surgery
❑ LASIK

R - L
❑ Strabismus (eye muscle surgery)
❑ Vitrectomy
❑ AG Laser Capsulotomy

Other ____

Current Eye Medications: (Please list and include which eye and how frequent)

____________________________ ____________________________ ____________________________

____________________________ ____________________________ ____________________________

Past Medical History: ❑ No history of illnesses

❑ Anemia
❑ Arthritis
❑ Arrhythmia
❑ Asthma
❑ Cancer
❑ Congestive Heart Failure
❑ COPD
❑ Diabetes (circle: Type 1 or Type 2)
❑ Fibromyalgia
❑ Headache
❑ Hearing Loss
❑ Heart Attack
❑ Hepatitis
❑ Herpes
❑ High Blood Pressure
❑ High Cholesterol
❑ HIV/AIDS
❑ Kidney Disease
❑ Liver Disease
❑ Lupus
❑ Migraine
❑ Multiple Sclerosis
❑ Polymyalgia Rheumatica
❑ Psychiatric Disorder
❑ Rheumatoid Arthritis
❑ Stroke
❑ Thyroid Disease
❑ Sleep Apnea
❑ Uses CPAP Machine

Other ____

Please continue on the back side of this page

Exam Date: _______________________

General Surgeries/Procedures: (Please list and give year)

______________________ ______________________ ______________________

______________________ ______________________ ______________________

All Other Medications: (Please list)

______________________ ______________________ ______________________

______________________ ______________________ ______________________

______________________ ______________________ ______________________

Family History: (Please indicate relationship) ❑ No history of illnesses ❑ History unknown

❑ Blindness
❑ Cancer
❑ Cataracts
❑ Diabetes
❑ Glaucoma
❑ Heart Disease
❑ High Blood Pressure
❑ Lazy Eye
❑ Macular Degeneration
❑ Retinal Disease
❑ Stroke
❑ Other______________________
❑ Migraines
❑ Thyroid Disease

Social History: (Please mark all that apply)

Smoking: ❑ current every day smoker ❑ current some day smoker ❑ former smoker ❑ never smoked

Alcohol Use: ❑ No ❑ Yes If yes, how much and how often? ______________________

Drug Use: ❑ No ❑ Yes If yes, which and how long? ______________________

Review of Systems: (Please mark all that apply)

Eyes
- ❑ Previous Surgery
- ❑ Contact Lens
- ❑ Pain
- ❑ Double Vision
- ❑ Glaucoma
- ❑ Cataracts
- ❑ Macular Degeneration
- ❑ Dry Eyes
- ❑ Flashes
- ❑ Floaters

Ear, Nose, and Throat
- ❑ Hard of Hearing
- ❑ Ringing in Ears
- ❑ Vertigo

Cardiovascular
- ❑ Chest Pain
- ❑ Dizziness
- ❑ Fainting Spells
- ❑ Shortness of Breath
- ❑ Irregular Heart Beat
- ❑ Difficulty Lying Flat

Constitutional
- ❑ Fatigue / Weakness
- ❑ Fever
- ❑ Weight Gain / Loss

Respiratory
- ❑ Cough
- ❑ Congestion
- ❑ Wheezing
- ❑ Asthma

Gastrointestinal
- ❑ Heartburn
- ❑ Nausea / Vomiting
- ❑ Jaundice / Hepatitis

Genitourinary
- ❑ Pain / Difficulty
- ❑ Blood in Urine
- ❑ History of Kidney Stones
- ❑ History of STD's

Psychiatric
- ❑ Anxiety / Depression
- ❑ Mood Swings
- ❑ Difficulty Sleeping

Endocrine
- ❑ Increased Thirst
- ❑ Increased Hunger
- ❑ Increased Urination
- ❑ Increased Sweating
- ❑ Fingernail Changes

Blood/Lymph Nodes
- ❑ Easy Bruising
- ❑ Gums Bleed Easy
- ❑ Prolonged Bleeding
- ❑ Heavy Aspirin Use

Musculoskeletal
- ❑ Stiffness
- ❑ Arthritis
- ❑ Joint Pain / Swelling

Skin
- ❑ Rash / Sores
- ❑ Lesions
- ❑ Hives / Eczema

Neurological
- ❑ Seizures
- ❑ Weakness / Paralysis
- ❑ Numbness
- ❑ Tremors

Immunologic
- ❑ Hives
- ❑ Itching
- ❑ Runny Nose
- ❑ Sinus Pressure

Patient Signature: ______________________ Date: ____________

Reviewed by:______________________ Date: ____________

Reviewed by:______________________ Date: ____________