CLEARVIEW EYECARE

Patient Information Form

(Please print)

Name _____ Today's Date _____ 20___
First MI Last

Address_____ City_____ State_____ Zip _____

Birth Date _____

Home Phone_____ Cell Phone _____ Work Phone _____

E-Mail _____

Are you: Minor○ Single○ Married○ Divorced○ Widowed○ Sex: Male○ Female○

Spouse or parents name (if minor) _____ Work phone _____

Number of Family Members:_____

Person to contact in case of an emergency _____Phone _____

How did you hear about us? _____

Vision Insurance Information:

Name of Vision Insurance Company: _____
Name of Insured: _____
Birth date of Insured: _____
Member ID: _____
Employer of Insured: _____
Relationship to Patient: _____

Medical Insurance Information:

(Copy of card required)

Name of Medical Insurance Company: _____
Name of Insured: _____
Birth date of Insured: _____
Member ID: _____
Employer of Insured: _____
Relationship to Patient: _____

INSURANCE SIGNATURE ON FILE

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits directly to Carole Paveglio, O.D. On my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (item 9 of the CMS-1500 claim form or electronically submitted claim), my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent as above. Patient is responsible for services not covered by insurance company.

_____

Patient Signature Date

Patient Verified Information is Correct: _____Date : _____
Patient Verified Information is Correct: _____Date : _____
Patient Verified Information is Correct: _____Date : _____

CLEARVIEW EYECARE

Patient Health Information

Name_____ Date _____
First Middle Last

Thank you for taking your time to carefully complete the patient health information form. This information will be reviewed by the doctor during your examination. All information provided will be held in strict confidence.

PERSONAL EYE HISTORY

- Have you ever had your pupils dilated? Y☐ N☐ If yes, were there any problems? _____
- Do you wear glasses? Y☐ N☐ If yes, how old are your glasses?_____
- Date of last complete eye exam _____Name of eye doctor _____
- Have you ever worn contact lenses? Y☐ N☐ Do you now wear contact lenses? Y☐ N☐
  What type of contact lenses? Hard/RGP☐ Soft☐ Extended☐ Bifocal☐
- Are you planning to get new glasses or contact lenses today? Contacts☐ Glasses☐ Both☐
- Are you interested in learning about laser vision correction or non-surgical vision correction? Y☐ N☐ Maybe☐

Please note any family members with the following conditions									
EYE CONDITIONS	Y	N	?	RELATIONSHIP	EYE CONDITONS	Y	N	?	RELATIONSHIP
♦ Blindness	◯	◯	◯		♦ Macular Degeneration	◯	◯	◯	
♦ Glaucoma	◯	◯	◯		♦ Other	◯	◯	◯	

PERSONAL MEDICAL HISTORY

- List medications you are currently taking (prescription, over-the-counter, and vitamins)

_____

_____

_____

- Do you have any allergies to medications? Y☐ N☐ If yes, please explain: _____

_____

- List major illnesses, injuries, and surgeries you have had _____

_____

- Date of your last physical exam _____ Are you pregnant / nursing? Y☐ N☐
- Name and office location of your medical doctor(s) _____

FAMILY MEDICAL HISTORY

Please note any family members with the following conditions.

MEDICAL CONDITIONS	Y	N	?	RELATIONSHIP	MEDICAL CONDITIONS	Y	N	?	RELATIONSHIP
♦ Arthritis	◯	◯	◯		♦ Heart Disease	◯	◯	◯	
♦ Cancer	◯	◯	◯		♦ High Blood Pressure	◯	◯	◯	
♦ Diabetes	◯	◯	◯		♦ Other	◯	◯	◯	

SOCIAL HISTORY

- What is your occupation? _____
- Do you use a computer at work or at home? Y◯ N◯
- List your hobbies/recreational activities. _____
- Do you drive? Y◯ N◯ If yes, do you have visual difficulty when driving? Y◯ N◯
- Do you use tobacco products? Y◯ N◯ If yes, what type/amount/how long?_____
- Do you drink alcohol? Y◯ N◯ If yes, how often? _____
- Do you use illegal drugs? Y◯ N◯
- Have you ever been exposed or infected with the following: HIV? Y◯ N◯ TB? Y◯ N◯

REVIEW OF SYSTEMS Do you now have or have you ever had any of the following health problems?

PROBLEMS	YES	NO	IF YES, PLEASE EXPLAIN
♦ Eyes			
♦ Eye injury or eye pain	○	○	
♦ Loss of vision	○	○	
♦ Blurred vision	○	○	
♦ Tired eyes	○	○	
♦ Redness	○	○	
♦ Itching	○	○	
♦ Burning	○	○	
♦ Sandy or dry eyes	○	○	
♦ Excessive tears (watery eyes)	○	○	
♦ Vision disturbance (spots, halos, light flashes)	○	○	
♦ Light sensitivity / glare	○	○	
♦ Double vision	○	○	
♦ Glaucoma	○	○	
♦ Cataract	○	○	
♦ Macular degeneration	○	○	
♦ Diabetic retinopathy	○	○	
♦ Amblyopia	○	○	
♦ Eye turn (eso- or exotropia)	○	○	
♦ Keratoconus	○	○	
♦ Learning disability	○	○	
♦ Review of Systems			
♦ Allergic (hay fever,etc)	○	○	
♦ Cardiovascular (high blood pressure, vascular disease, etc)	○	○	
♦ Constitutional (fever, weight loss)	○	○	
♦ Ears, Nose, Mouth, Throat (sinus, chronic cough, etc)	○	○	
♦ Endocrine (diabetes, thyroid, etc)	○	○	
♦ Gastrointestinal (diarrhea, constipation, ulcers, etc)	○	○	
♦ Genitourinary (genitals, kidney, bladder)	○	○	
♦ Blood/Lymph (anemia, high cholesterol, etc)	○	○	
♦ Immunologic (lupus, etc)	○	○	
♦ Skin	○	○	
♦ Muscles/Bones/Joints (arthritis, etc)	○	○	
♦ Neurological (headaches, multiple sclerosis, etc)	○	○	
♦ Psychiatric (anxiety, depression, etc)	○	○	
♦ Respiratory (asthma, emphysema, etc)	○	○	

Physician's Signature: _____ Date: _____

PATIENT RECORD OF DISCLOSURE

In general, the **HIPAA** privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to require confidential communications or other communications of **PHI** be made by alternative means such as:

I wish to be contacted in the following manner (check all that apply)

Home Telephone: _____

☐ OK to leave message with detailed information

☐ Leave message with call back number only

☐ OK to leave message with family member

Work Telephone: _____

☐ OK to leave message with detailed information

☐ Leave message with call back number only

Written Communication

☐ OK to mail to my home address

☐ OK to mail to my work office address

_____	_____	_____
Patient Signature	Print Name	Date

Notice and Acknowledgment

Acknowledgment:

I acknowledge that I have received the attached Notice of Privacy Practices.

_____	_____
Patient or Personal Representative Signature	Date

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient.

_____

_____

_____