WELCOME TO CARENCRO EYE CLINIC!
PLEASE COMPLETE THE FORM BELOW AS COMPLETELY AS YOU CAN.

STEP 1 – PATIENT REGISTRATION

Patient Name:

_____
(Last) (First) (MI)

Address:_____

_____
(city) (state) (zip)
Social Security No.:_____-_____-_____
Birthdate:_____/_____/_____
Sex: (circle one) Male Female
Employer or School: _____
Occupation or Grade: _____
Home Phone :(__)_____
Work Phone: (__) _____
Cell Phone :(__)_____
Email Address:_____

Which method do you prefer to receive appointment reminders: (please circle one) **Text Email US Mail**

Ethnicity:
__Hispanic/Latino __Not Hispanic/Latino __Unknown __Decline to Answer

Race: __African American __Caucasian(White) __Asian__American Indian/Alaska Native __Native Hawaiian/Pacific Islander __Decline to answer __Other: _____

In Case of Emergency, Contact:
Name:_____
Relationship:_____
Home Phone:_(___)_____
Cell Phone:_(___)_____
Work Phone:_(___)_____

I authorize the following people to be able to obtain or handle matters in regards to my protected health information on my behalf. I understand that **NO ONE** will be given information or be allowed to handle **ANY** matters on my behalf if they are not listed below and that at any time if I wish to add or remove names from this list must be done so in **writing**:

_____
_____
_____

STEP 1 –PATIENT REGISTRATION CON'T

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT
I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, and the practice's legal duties with respect to my protected health information. I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

_____/_____
Responsible Party Signature **(Date)**

_____/_____
Printed Name Relationship to patient

STEP 2 –RECREATIONAL HEALTH INQUIRY

Do you currently wear: ___Glasses ___ Contacts
If currently a contact lens wearer which:
Brand of contacts do you wear: _____
Brand of Solution do you use: _____

If prescription is needed, are you interested in:
__Glasses __ Contacts

****NOTE**: If interested in contacts, please be aware that there is an additional charge for contact lens fitting and materials; it is not included in the comprehensive eye. Inquire at front desk for more information.

Do you use a computer: __ Yes __NO Hrs. /day ___

Please indicate any hobbies or interests:

__ fishing __golfing __reading __sewing __music

__ sports __dancing __other: _____

Please indicate which substances you use:
___Alcohol ___Tobacco ___Drugs/other

STEP 3 –COMPREHENSIVE MEDICAL HISTORY QUESTIONNAIRE

PLEASE CIRCLE ANY OF THE FOLLOWING CONDITIONS THAT YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST:

Pregnant now Y N Due: _____	**Allergies Y N**	**Asthma/Respiratory Y N**
Eye Diseases Y N	**Diabetes Y N Type 1 or 2**	**Arthritis Y N**
Eye Injuries Y N	**Cancer Y N**	**Heart Disease Y N**
Eye Surgery Y N	**Thyroid Y N**	**High Blood Pressure Y N**
Lazy Eye Y N	**Kidney Y N**	**Nerve Problems Y N**
Cataracts Y N	**HIV/Blood Y N**	**Psychiatric Y N**
Glaucoma Y N	**Fever Y N**	**Weight Loss Y N**
Skeletal Y N	**Stomach Y N**	**Genitourinary Y N**
Ear Y N	**Nose Y N**	**Mouth/Throat Y N**

PLEASE CIRCLE ANY OF THE FOLLOWING CONDITIONS THAT ARE IN YOUR FAMILY HISTORY: (mother, father, siblings)

Blindness Cataracts Glaucoma Diabetes High Blood Pressure Retinal Detachments
Heart Disease Macular Degeneration Other Conditions: _____

Please list any and all medications: (prescription or over-the-counter):

_____

_____

Please list all known drug allergies below:

_____

PLEASE CIRCLE ANY OF THE FOLLOWING CONDITIONS THAT APPLY TO YOUR EYES:

Burning Redness Dryness Gritty Sensation Light Sensitivity Spots Floaters Night Blindness Double Vision Dizziness Flashes of Light Headaches Dizziness Other:_____

In case a prescription is needed please fill out the information below for which pharmacy you would like us to use:

Pharmacy Name: _____
Phone Number: _____
Fax Number: _____

STEP 4 –HEALTH/VISION INSURANCE

Insurance Company: _____
Primary Member: _____
Relationship to Patient: _____
Birthdate: ___/___/____SS#:_____-_____-_____

Is patient covered by additional insurance: (circle one)
YES NO
Insurance Company: _____
Primary Member: _____
Relationship to Patient: _____
Birthdate:___/___/____SS#:_____-_____-_____

SIGNATURE ON FILE

I authorize use of this form on all my insurance submissions.
I authorize the release of information to all my insurance companies.
I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies.
I authorize payments direct to my doctor.
I permit a copy of this authorization to be used in the place of the original.
I understand that payment is expected on the day of services.
I understand that any charges that my insurance doesn't cover (non-covered services) as well as my deductible and co pays are my financial responsibility.

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with the plan(s) listed above and assign directly to the Provider all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the Provider to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature:_____ Date: _____

****Please present insurance cards to front desk upon completion of paper work. Thank You!!****

Method of Payment: cash, credit card, Medicaid, Medicare, VSP, other _____