DR. CARLSON & ASSOCIATES

In Office Use Only		
OCT	☐ Y	☐ N
Retinal Photos	☐ Y	☐ N
Add Refraction	☐ Y	☐ N

Patient Registration Form:

Name (First) _____ (MI) ____ (Last)_____ Gender: M F

Address _____ City _____ State _____ Zip _____

Telephone (H) _____ (Cell/Work) _____ DOB ____/____/_____ SS# _____-____-_____

Occupation_____Employer _____Email _____ Single ☐ Married ☐

Health Insurance Carrier_____ Vision Insurance Carrier_____

Have You ever been to this office before? ☐ **YES** ☐ **NO** When was your last Eye Examination? _____

Eye Health / History : (Please check all that apply)

What Problems are you currently having?

☐ Blurred Vision	☐ Burning	☐ Discharge	☐ Pain/Soreness
☐ Halos/ Glare	☐ Itching	☐ Headaches	☐ Contact Lens Problems
☐ Flashes/ Floating spots	☐ Dryness	☐ Watering	☐ Peripheral Vision Loss
☐ Redness	☐ Double Vision	☐ Foreign Body sensation	Other _____

Have you ever been told you have any of these or have any family history of these? (Please check all that apply)

☐ Cataracts	☐ Glaucoma	☐ Retinal Detachment	☐ Melanoma of Eye
☐ Dry Eye	☐ Macular Degeneration	☐ Retinitis Pigmentosa	☐ Corneal Dystrophy
☐ Lazy eye	☐ Crossed eyes	☐ Blindness	Other _____

Do you now wear contact lenses? ☐ **YES** ☐ **NO** If no, have you worn them in the past? ☐ **YES** ☐ **NO**

Are you Interested in Contact lenses even for occasional use? ☐ **YES** ☐ **NO** Are you Interested in LASIK ☐ **YES** ☐ **NO**

Have You ever had an Eye injury, surgery or bad infection? ☐ **YES** ☐ **NO** Explain _____

DILATION INFORMED CONSENT: Dilation is recommended every 2-3 years, even in healthy eyes. Dilation may be required more frequently by your eye doctor for many ocular and systemic conditions. Many serious and sometimes vision threatening conditions cannot be accurately diagnosed or detected without dilation. Dilation will make you light sensitive, and will make your distance and reading vision blurry. Driving is usually safe when dilated, and the patient assumes all risk of operating a motor vehicle, as well as any other visually demanding tasks, while dilated.

DO YOU WISH TO BE DILATED TODAY? ☐ **YES** ☐ **NO** ☐ **IF NECESSARY**

Medical History (Please Check all that apply to you, circle if Family History only)

Approximate Height _____	☐ Anxiety	☐ Ulcers	☐ Thyroid disease
Approximate Weight _____	☐ Bipolar Disorder	☐ Currently Pregnant	☐ Rheumatoid arthritis
☐ Sinus Congestion	☐ Heart disease	☐ Degenerative Disk	☐ Lupus
☐ Hearing Loss	☐ Artery disease	☐ Muscular Dystrophy	☐ Sjogren's disease
☐ Multiple Sclerosis	☐ Hypertension	☐ Fibromyalgia	☐ HIV/AIDS
☐ Cerebral palsy	☐ High Cholesterol	☐ Osteoporosis	☐ Smoker
☐ Parkinson's	☐ Asthma	☐ Rosacea	☐ Consume Alcohol
☐ Migraines	☐ COPD	☐ Shingles	Other _____
☐ Stroke	☐ Colitis	☐ Diabetes Type 1	
☐ Depression	☐ Crohn's Disease	☐ Diabetes Type 2	

Medications (Please list any current Medications you take, if you do not know the name- then what you take it for)

1.	2.	3.	4.
5.	6.	7.	8.

Are allergic to any medications? Yes ☐ No ☐ Please List _____

Are there any other conditions we should Know about? Yes ☐ No ☐ Explain _____

DR. TORREY J. CARLSON & ASSOCIATES, P.C.

HIPAA PRIVACY

I acknowledge and agree that I have been informed that this office abides by the HIPAA laws and am entitled to a copy of the Notice of Privacy Practices for review and, if desired, to keep for my records on the date identified below.

I understand that the Office may use and disclose necessary personal health information (for example, my name, address, subscriber identification number, eye exam information and/or type of products provided) to another party to permit the Office to perform its administrative duties, provide me with eye care services and products, process my vision/medical benefits claims and communicate with me regarding vision care services/products provided by the Office (for example, mailings of exam reminders or information about services/products provided by the Offices).

I can be assured that this Office does not sell my personal health information of any kind to a third party for such party's own use. I authorize the Office to submit my vision/medical benefits claims to my plan sponsor or health plan to receive reimbursement directly for the vision services and products that I have received from the Office.

X_____

Patient Signature or Patient's Legal Representative Date

I authorize Dr. Torrey J. Carlson & Associates to release my **complete medical records** and other documentation made by doctors or personnel for the entire time I was treated by the Practice to the following family members, friends or other care givers who contact us for purposes of providing them with information related to my treatment and/or payment obligations:

Name: _____Relationship:_____

Name:_____ Relationship_____

I understand the practice may need to contact me for purposes related to my treatment such as; related to my treatment, appointments, referrals, and billing business.

My preferred method of communication is:

☐ **Phone/text (voice messages may be left)**

☐ **Email**

☐ **Postcard**

☐ **Any of the above**

X_____

Patient's Signature or Patient's Legal Representative Date

I hereby authorize the use of my above email or address . I understand I can revoke this authorization at any time and the au-

Insurance/ Medicare Release

I authorize the release of any information required to process an insurance claim. I understand that I am responsible for payment of any amounts not covered by my insurance plan. By signing below, I submit all health information disclosed is accurate. I authorize the Office to receive insurance payments directly for the services I have received.

X_____

Patient Signature or Patient's Legal Representative Date

Email _____

Due to new healthcare regulations involving healthcare portals and meaningful use of patient records, we need an email address on file.