Welcome to Maplewood Eye Care Center

Patient Registration and Medical History

Today's Date:_____

Patient's full Name_____ Date of Birth _____

Name preferred to be called:_____ If child, parent's name: _____

*Race: (circle) White Hispanic African American Asian Other Ethnicity: Hispanic Non-Hispanic Unknown

*Primary Language: English Spanish Non-Verbal Communication Preference: Telephone or Mail

Soc. Sec. # _____ Email: _____@ _____ Referred by:_____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Check one: ☐Single ☐Married ☐other

Employment: ☐Full Time ☐Part Time ☐Retired ☐Student Occupation: _____

If a student: ☐Full Time ☐Part Time School Name/ Grade:_____ _____

Employer's Name _____Business Phone:_____

A Refraction (the measurement of your eye's needed for an eyeglass prescription) is typically not a covered benefit of insurance plans. The **fee for the refraction is $34.00 and is performed during your complete/yearly exam.** We will submit this service to your insurance, however most insurance have limitations for this service.

You will be financially responsible for your account: For professional services, if your insurance bill exceeds $100, we will gladly file your insurance. You will be responsible for paying the co-payment at the time of your visit. You will receive a copy of your itemized charges so that you may file with your insurance. For optical services, ordering prescription eyewear / contact lenses requires a minimum 50% deposit at the time of ordering with the balance due in full at the time of dispensing.

Signature on File: We are required to obtain your signature so that standard, required insurance forms may be completed properly. Please provide your signature in the space below. 1) I authorize use of this form on all my insurance submissions.
2) I authorize release of information to my insurance carrier. 3) I understand that if my insurance does not pay, I will be responsible for the services rendered. 4) I authorize payment to my doctor. 5) A copy of this authorization may be used in place of the original.

Print Name: _____ **Signature:** _____

HIPPA

By signing here, I am consenting to allow Maplewood EyeCare Center to use and disclose my PHI to the name (s) listed below:

_____

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

I acknowledge that I have read/received a copy of Maplewood EyeCare Center's Notice of Privacy Practices.
Patient name: _____ Signature : _____

MEDICAL HISTORY

The following information is essential for this office to provide eye care in a manner that is compatible with your general health. Your cooperation in providing accurate information is necessary to meet your eye health and vision needs safely and efficiently. Incorrect information can be dangerous to your health. Your answers are for your medical records only and will remain CONFIDENTIAL. Thank you for your assistance.

Name of your primary care physician:_____Phone _____

Name of your pharmacy: _____

* "Meaningful Use (MU)" is a government program to ensure that healthcare professionals are utilizing their Electronic medical Record (EMR) system efficiently to improve healthcare quality. A core MU is to record patient demographics.

Medical history continued on reverse side

Please list all medications taken (including birth control, eye drops, OTC medications, herbs vitamins etc.):

_____

_____

Are you currently under the care of a physician? ☐Yes ☐No If yes, what is the reason or condition?

_____

_____

List all medications that you are allergic to or cannot take: _____

_____

PERSONAL EYE INFORMATION

Is there a family history of cataract, glaucoma, macular degeneration or other eye condition? _____

Have you had any eye surgeries, injuries or serious conditions? Yes or No. If yes, please describe: _____

When was your last eye exam? _____. Where glasses prescribed/ Yes or No

CONTACT LENS EXAM: Are we providing contact lens services today? Yes or No. If yes ***PAYMENT IS DUE AT THE TIME OF SERVICE***. Contact lens service, initial fitting, refitting etc., are not part of a complete exam and represent additional out of pocket expenses. If you have any questions, please inquire about fees before services are rendered. These fees apply to all contact lens exam patients.

CONTACT LENS HISTORY:

Do you wear contacts? YES or NO How many years? _____ Type of Solution: _____

Brand of Contacts: _____ Type: Soft or RGP Age of current lenses: _____

Number of hours/days: _____ Do you sleep in contacts? Yes/No

How often do you replace your contacts? Daily 2 weeks Monthly Yearly I wear them until they bother me

PLEASE PLACE A CHECK MARK (✓) BY ANY OF THE FOLLOWING HEALTH CONDITIONS BELOW THAT APPLY TO YOU:

- o Allergies to drugs
- o Headaches
- o Fluctuating vision
- o Decreased Vision
- o Double vision
- o Watering eyes
- o Eye / eyelid redness
- o Eye / eyelid dryness
- o Eye / eyelid itching
- o Eye / eyelid pain
- o Eye / eyelid discharge
- o Eyelid /eyelash crusting
- o Sun /glare sensitivity
- o Floaters or Flashes
- o Glaucoma
- o Low blood pressure
- o High blood pressure
- o Heart disease
- o Diabetes

Sugar level _____

A1C _____

- o High Cholesterol
- o Head Injury
- o HIV/AIDS
- o Hepatitis B
- o Hepatitis C
- o Bipolar / ADHD
- o Lung disease
- o Asthma
- o Seizures
- o Head trauma
- o Stroke
- o Depression
- o Arthritis
- o Kidney trouble
- o Thyroid disease
- o Hay fever or sinus trouble
- o Jaundice, hepatitis Liver disease
- o Blood disorder/ Anemia
- o Disability? Type? _____

Social History

Do you smoke? Yes / No How Long? _____ How Many packs per day? _____

Are you a: Current Every day Smoker Light Smoker (1-9 cig/day) Heavy Smoker (10 or more cig/day)

Are you a former smoker? YES or NO How Long? _____ Narcotic Use? None Chemical Recreational

Do you drink alcohol? YES or NO How Long? _____

How often? Social Only 1-2 daily Above average

Thank you for your assistance