Patient Information

Today's Date:_____			Primary Care Doctor:_____	
Patient's last name:	First:	Middle:	Marital status (circle one) Single / Mar / Div / Sep / Wid	❑ Male ❑ Female
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	SSN:	Birth date: / /	Age:
Street address:		Cell phone: ( )	Home phone: ( )	
P.O. box:	City:	State:	ZIP Code:	
Occupation:	Employer:	Employer phone no.: ( )		
Referred to clinic by:		Ph no.:		
Other family members seen here:				

INSURANCE INFORMATION

Is this patient covered by insurance? ❑ Yes ❑ No *if **no**, please provide the responsible party's **name**, **date of birth** and **social security number** below

Primary Insurance:

Subscriber's name:	Subscriber's SSN:	Birth date: / /	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance:	Subscriber's name:	Group no.:	Policy no.:
Subscriber's SSN:	Birth date: / /		

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not at same address) :	Relationship to patient:	Home phone: ( )	Cell phone: ( )

Signature on File: I authorize (1) the use of my signature on all of my insurance submissions, (2) release of information to all of my insurance companies, (3) my doctor to act as my agent in helping me obtain payment from my insurance carrier, (4) payment directly to my doctor and (5) a copy of this authorization in place of the original.

I understand that (1) I am responsible for my bill, (2) that if my account is turned over to collections, there will be a **31%** charge added to my bill and (3) there will be a **$35.00** charge to my account for all returned checks.

- Medicare will **ONLY** pay for services it determines to be "reasonable and necessary" under §1862(a)(1) of Medicare Law. If Medicare and/or other insurance companies determine a particular service is not covered **you will be responsible for that service**. Medicare and some other insurances may deny payment for routine eye examinations and refractions. **Eyeglasses, contact lenses and measurements will be an out of pocket expense for ALL patients**.

***Beneficiary Agreement**: I have read and understand the above*

Signature Date

Name_____ **Age**_____**Today's Date**_____

Eyes

Previous surgery	☐Yes ☐No
Contact lens	☐Yes ☐No
Pain	☐Yes ☐No
Double vision	☐Yes ☐No
Glaucoma	☐Yes ☐No
Cataracts	☐Yes ☐No
Macular Degen.	☐Yes ☐No
Dry eyes	☐Yes ☐No
Redness	☐Yes ☐No
Tearing	☐Yes ☐No
Blur	☐Yes ☐No
Flashes/Floaters	☐Yes ☐No

Ear, Nose, and Throat

Hard of hearing	☐Yes ☐No
Ringing in Ears	☐Yes ☐No
Vertigo	☐Yes ☐No
Pain on chewing	☐Yes ☐No
Sore throat	☐Yes ☐No

Cardiovascular

Chest Pain	☐Yes ☐No
Dizziness	☐Yes ☐No
Fainting Spells	☐Yes ☐No
Shortness of Breath	☐Yes ☐No
Irregular Heart Beat	☐Yes ☐No
Difficulty Lying Flat	☐Yes ☐No
Palpitations	☐Yes ☐No

Constitutional

Fatigue/Weakness	☐Yes ☐No
Fever	☐Yes ☐No
Weight Gain/Loss	☐Yes ☐No

Are you Diabetic? ☐Yes ☐No
BSL_____ Type_____

Respiratory

Cough	☐Yes ☐No
Congestion	☐Yes ☐No
Wheezing	☐Yes ☐No
Asthma	☐Yes ☐No
Shortness of breath	☐Yes ☐No
Sneezing	☐Yes ☐No

Gastrointestinal

Heartburn	☐Yes ☐No
Nausea/Vomiting	☐Yes ☐No
Jaundice/Hepatitis	☐Yes ☐No

Genito-Urinary

Pain/difficulty	☐Yes ☐No
Blood in Urine	☐Yes ☐No
History of Kidney Stones	☐Yes ☐No
History of STD's	☐Yes ☐No
Dysuria	☐Yes ☐No
Difficulty with urine flow	☐Yes ☐No

Psychiatric

Anxiety/Depression	☐Yes ☐No
Mood Swings	☐Yes ☐No
Difficulty sleeping	☐Yes ☐No

Endocrine

Increased Thirst	☐Yes ☐No
Increased Hunger	☐Yes ☐No
Increased Urination	☐Yes ☐No
Increased Sweating	☐Yes ☐No
Fingernail Changes	☐Yes ☐No
Heat or Cold Intolerance	☐Yes ☐No

Blood/Lymphnodes

Easy Bruising	☐Yes ☐No
Gums bleed easily	☐Yes ☐No
Prolonged bleeding	☐Yes ☐No
Heavy Aspirin use	☐Yes ☐No

MusculoSkeletal

Stiffness	☐Yes ☐No
Arthritis	☐Yes ☐No
Joint/Pain Swelling	☐Yes ☐No
Shoulder pain	☐Yes ☐No

Skin

Rash/Sores	☐Yes ☐No
Lesions	☐Yes ☐No
Hives/Eczema	☐Yes ☐No
Itchy Eyes	☐Yes ☐No
Scalp tenderness	☐Yes ☐No

Neurological

Seizures	☐Yes ☐No
Weakness or Paralysis	☐Yes ☐No
Numbness	☐Yes ☐No
Tremors	☐Yes ☐No
Difficulty speaking	☐Yes ☐No

Immunologic

Hives	☐Yes ☐No
Itching	☐Yes ☐No
Runny nose	☐Yes ☐No
Sinus Pressure	☐Yes ☐No

Do you smoke? □Yes □No *if yes, how often _____
Do you drink alcohol? □Yes □No *if yes, how often_____

Paul S. Cunningham, MD
Andrew F. Kolker, MD
HIPAA OMNIBUS RULE
PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

_____ _____

Please *print* name of Patient Please *sign* for Patient / Guardian of Patient

_____ _____

Legal Representative / Guardian Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: _____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

☐ First Name Only ☐ Proper Surname ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ Any of the Above

I AUTHORIZE INFORMATION ABOUT MY HEALTH BE CONVEYED VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ Any of the Above

I APPROVE BEING CONTACTED ABOUT SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO on behalf of this Healthcare Facility via:

Phone Message
Text Message
Email
☐ Any of the Above
☐ None of the above (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment _____
I could not communicate with the patient _____
The patient refused to sign _____
The patient was unable to sign because _____
Other (please describe) ____ _____

Signature of Privacy Office

Signature Date

Signature Date

Medical History

Check off any Medical Problems:

☐ Premature Birth ☐ Diabetes ☐ Hypertension (High Blood Pressure) ☐ Thyroid Disease

☐ Cancer (Type: _____ Are you currently undergoing chemotherapy? □Yes □No)

List any other medical problems that other doctors have diagnosed:

Surgeries	
Year	Reason

Other hospitalizations	
Year	Reason

Preferred Pharmacy :	Phone:	Fax:
Address	Zip Code:	

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers:		
Name of the Drug	Strength	Frequency Taken

Allergies to medication:	
Name of Drug	Reaction you had:

Family History		
Do you have any family members with Glaucoma?	□ Yes	□ No
If yes, what is their relationship? (i.e. mother, father, etc.)		
Do you have any family members with Lazy Eye or Crossed Eyes?	□ Yes	□ No
If yes, what is their relationship? (i.e. mother, father, etc.)		