PORT ROYAL EYECARE

Patient Information & Medical History

First Name: _____ Last Name: _____ Middle Initial: ___ Sex: M ☐ F ☐

Preferred Name: _____ Birth Date: _____ Social Security Number: _____

Home Address: _____

Zip: _____ City: _____ State: _____ What is your occupation? _____

Race: ☐ African/African American ☐ Asian/Asian American ☐ Caucasian/European American ☐ Native America ☐ Other ☐ Decline

Ethnicity: ☐ Non-Hispanic ☐ Hispanic / Latino

Height:_____ **Weight:**_____

How would you prefer we use to contact you? ☐ Home ☐ Work ☐ Cell ☐ E-mail E-mail address _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Marital Status: ☐ Single ☐ Married How did you hear about us? _____ ***We must have a copy of all insurance cards on the day of service****

Primary Medical Insurance: _____ Secondary Medical Insurance: _____

Vision Insurance: _____ Insured's Name_____ Insured Social Security Number: _____

Insured's Birth Date:_____ Insured's Employer: _____

Family Doctor: _____ Family Dr. Clinic/Phone: _____

Family Members: _____ For ease of data transfer, are they patients at this office? Y ☐ N ☐

NOTICE OF PRIVACY PRACTICES: I/We have been offered a copy of Port Royal Eye Care statement on privacy practices
AUTHORIZATION TO RELEASE INFORMATION: I/We hereby authorize Port Royal Eye Care to release any medical or incidental information that may be necessary for medical benefit of in processing applications for financial benefit. This includes but is not limited to my insurance company, Rehabilitation Services, Social Security Administration, and Worker's Compensation.
CONSENT FOR TREATMENT: I/We hereby authorize Port Royal Eye Care to administer diagnostic and medical procedures as may be necessary for proper health care.
OFFICE POLICY ON PAYMENT: I understand that I am responsible for payment of all charges. As a courtesy, my insurance will be billed for me. It is my responsibility to pay any deductible, copay or any other balance not paid by my insurance company. I authorize insurance benefits to be paid directly to the provider.
VISION PLAN COVERAGE: I/We understand that only one vision plan may be used for exam/materials per visit-per patient and that the vision plan to be used must be chosen before the exam occurs and can not be billed or changed at a later date.

SIGNATURE: _____ DATE: _____

CHIEF COMPLAINT

How can we help you today? In this space please check/explain any signs and/or symptoms you are experiencing. Medical insurance will only cover if there is a medical reason for the exam/test such as loss of vision, headaches, eye pain, eye itching or burning, redness, glaucoma, cataracts, floaters, dry eyes, etc.

☐ Loss of vision	☐ Floaters	☐ Eye pain/soreness	☐ Glare	☐ Dry eyes
☐ Blurred vision	☐ Crossed eyes	☐ Watery eyes	☐ Light sensitivity	☐ Red eyes
☐ Double vision	☐ Flashes of light	☐ Sandy/gritty feeling	☐ Tired eyes	☐ Burning/itching

Other (explain):

HISTORY OF PRESENT ILLNESS

Location *Which eye has the problem?* ☐ Right ☐ Left ☐ Both
Quality *How is it effecting you?* ☐ Bothersome ☐ Aware ☐ Painful
Severity *How severe is the problem?* ☐ Mild ☐ Moderate ☐ Severe
Duration *How long have you had the problem?* _____

Timing *Is it new, ongoing, returning?* ☐ New ☐ Ongoing ☐ Returning
Context *Associated w/:* ☐ Infection ☐ Medical condition ☐ Injury ☐ Surgery
Modifiers *Previous treatment?* ☐ Drops ☐ Medication ☐ Other: _____
Symptoms *Are there associated symptoms?* ☐ Headache ☐ Other: _____

FAMILY HISTORY

Has anyone in your family been diagnosed with any of the following (check all that apply):
☐ No problems ☐ Diabetes ☐ High blood pressure ☐ Cancer
Who: _____ _____ _____

Has anyone in your family been diagnosed with any of the following eye problems (check all that apply):
☐ No problems ☐ Glaucoma ☐ Amblyopia ☐ Cataracts ☐ Macular degeneration ☐ Strabismus (eye turn)
Who: _____ _____ _____ _____ _____

SOCIAL HISTORY

Do you smoke? ☐Y ☐N ☐Former
If yes, what do you smoke? ☐Cigarettes ☐Cigars ☐Pipes
How much per month do you smoke? _____

Do you consume alcohol? ☐Y ☐N
If yes, how much do you drink? ☐Socially ☐Daily

CURRENT VISION Last Vision Exam_____ Last Eye Doctor_____

Glasses: Do you currently wear glasses? ☐Y ☐N *if yes, answer the questions below; if no, continue to contact lenses section:*
What type of lenses are in your glasses? ☐Single vision ☐Bifocal ☐Trifocal ☐No-line (Progressive)

Contact Lenses: Do you currently wear contact lenses? ☐Y ☐N *if yes, answer the questions below; if no, continue to past ocular history section:*
What type of contact lenses do you wear? ☐Soft ☐Rigid
What is the manufacturer/model of your contact lenses? _____
What are the powers of your contact lenses (if you know)? _____
How old are your current contact lenses? _____ **Months / Years**
Do you sleep in your contact lenses? _____ How many nights in a row? _____
How often do you replace your contact lenses? ☐Daily ☐Weekly ☐2 weeks ☐Monthly ☐3 months ☐6 months ☐Annually
What solutions do you use to care for contact lenses? ☐Renu ☐Optifree ☐Clear Care ☐Boston Advance ☐Boston Simplicity ☐Optimum ☐Other: _____

REVIEW OF SYSTEMS

Ocular/Eye Problems
- Inflammatory disorder ☐Y ☐N
- Surgery ☐Y ☐N
- Glaucoma ☐Y ☐N
- Amblyopia (lazy eye) ☐Y ☐N
- Cataract ☐Y ☐N
- Retinal problems ☐Y ☐N
- Macular degeneration ☐Y ☐N
- Strabismus (eye turn) ☐Y ☐N
- Patching ☐Y ☐N
- Other _____

Constitutional Problems
- Cancer Type:_____ ☐Y ☐N
- Fatigue ☐Y ☐N
- Developmental disability ☐Y ☐N
- Other _____

Ears, Nose, Mouth, Throat Problems
- Laryngitis ☐Y ☐N
- Dry mouth ☐Y ☐N
- Hearing loss ☐Y ☐N
- Sinusitis ☐Y ☐N
- Other _____

Neurological Problems
- Cerebral palsy ☐Y ☐N
- Multiple sclerosis ☐Y ☐N
- Tumor ☐Y ☐N
- Epilepsy ☐Y ☐N
- Other _____

Psychiatric Problems
- Depression ☐Y ☐N
- Other _____

Cardiovascular Problems
- Vascular disease ☐Y ☐N
- Stroke ☐Y ☐N
- Congestive heart failure ☐Y ☐N
- Heart disease ☐Y ☐N
- High blood pressure ☐Y ☐N
- High Cholesterol ☐Y ☐N
- Other _____

Respiratory Problems
- Emphysema ☐Y ☐N
- Bronchitis ☐Y ☐N
- COPD ☐Y ☐N
- Asthma ☐Y ☐N
- Other _____

Gastrointestinal Problems
- Colitis ☐Y ☐N
- Chron's disease ☐Y ☐N
- Ulcer ☐Y ☐N
- Other _____

Genitourinary Problems
- Prostate disease/cancer ☐Y ☐N
- STD Type:_____ ☐Y ☐N
- Kidney disease ☐Y ☐N
- Other _____

Musculoskelatal Problems
- Ankylosis spondylitis ☐Y ☐N
- Fibromyalgia ☐Y ☐N
- Muscular dystrophy ☐Y ☐N
- Osteoarthritis ☐Y ☐N
- Other _____

Skin Problems
- Rosacea ☐Y ☐N
- Psoriasis ☐Y ☐N
- Eczema ☐Y ☐N
- Other _____

Endocrine Problems
- Insulin dependent diabetes ☐Y ☐N
- Non-insulin diabetes ☐Y ☐N
- Hormonal dysfunction ☐Y ☐N
- Thyroid dysfunction ☐Y ☐N
- Other _____

Blood/Lymph Problems
- Large volume blood loss ☐Y ☐N
- Anemia ☐Y ☐N
- Rheumatoid arthritis ☐Y ☐N
- Other _____

Allergy/Immunologic Problems
- Environmental allergies ☐Y ☐N
- Drug allergies ☐Y ☐N
- Lupus ☐Y ☐N
- Other _____

Do you sometimes experience dry eyes? ☐Y ☐N

Are your eyes sensitive to sunlight? ☐Y ☐N

Do you work at a computer ? ☐Y ☐N

Problems with reflections and/or glare? ☐Y ☐N

Prefer not to wear your glasses at times? ☐Y ☐N

Interested in newer contact lens technology? ☐Y ☐N

Want information on thinner / lighter lenses? ☐Y ☐N

Want information on LASIK vision surgery? ☐Y ☐N

Want a non-surgical option to LASIK? ☐Y ☐N

Do you have any children? ☐Y ☐N

Do you spend time outdoors? ☐Y ☐N

Please list your sporting activities / hobbies:

_____

List any medications you are currently taking:

_____

_____

_____

List any medicine allergies:

_____

List any other allergies:

_____

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Acknowledgement of Privacy Policy and Practices

Port royal Eye Care Privacy Policy and Practices provides information regarding how we may use and disclose protected health information about you. According to HIPPA regulations, you have the right to a copy of the Privacy Policy and Practices before signing this consent form. The terms of our Privacy Policy may change and you may obtain a revised copy through our office.

You have the right to request how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, the agreement will be honored.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, diagnosis, payment, and health care operations including: communications via email, telephone, text messaging, and mail for appointment scheduling and reminders.

You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent.

I understand that:

- Protected health information may be disclosed or used for the treatment, payment, or health care operations.
- Port Royal Eye Care has a Privacy Policy and Practices and the patient has had the opportunity to review the policy.
- Port Royal Eye Care reserves the right to change the Privacy Policy and Practices.
- The patient has the right to restrict uses of their information, but Port Royal Eye Care does not have to agree to those restrictions.
- The patient may revoke this consent in writing at any time and all future disclosures will cease.
- Port Royal Eye Care may condition treatment upon execution of this consent.

I HERBY AUTHORIZE THE FOLLOWING PERSON(S) TO HAVE ACCESS TO MY FINANCIAL AND MEDICAL RECORDS:

Name:_____ Relation:_____ Phone:_____

Name:_____ Relation:_____ Phone:_____

_____ _____
Signature Date

I authorize that my email may be used to send contact and glasses prescriptions at the end of my visits. **_____**
Initials

(If initials and email address not provided, prescription cannot be sent until written documentation provided to our office)
Verbal consent is not valid