PATIENT INFORMATION

LAST NAME: _____ FIRST NAME: _____ M.I. ____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

DATE OF BIRTH: _____

HOME PHONE: (____) _____ CELL PHONE: (____) _____

SS #: _____ MARITAL STATUS: _____ STUDENT: FT OR PT

E-MAIL ADDRESS: _____

PATIENT EMPLOYER: _____ OCCUPATION: _____

PRIMARY CARE PHYSICIAN: _____ PHONE #: _____

PHARMACY NAME: _____ PHONE #: _____

GUARANTOR INFORMATION

RELATIONSHIP OF PATIENT TO GUARANTOR: SELF ____ SPOUSE ____ PARENT ____ OTHER ____

LAST NAME: _____ FIRST NAME: _____ M.I. ____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: (____) _____ CELL PHONE: (____) _____

SS#: _____ D.O.B: _____

PREFERRED LANGUAGE: _____

RACE: _____

ETHNICITY: _____

PREFERRED COMMUNICATION: MOBILE _____ HOME PHONE _____ MAIL _____

THERE WILL BE A $25.00 CHARGE FOR MISSED AND NO SHOW APPOINTMENTS, SO PLEASE CALL TO CANCEL.

INSURANCE

PRIMARY INSURANCE: _____

MEMBER ID: _____ GROUP #: _____

POLICY HOLDER: _____ SS#: _____ D.O.B: _____

SECONDARY INSURANCE: _____

MEMBER ID: _____ GROUP#: _____

POLICY HOLDER: _____ SS#: _____ D.O.B: _____

EMERGENCY CONTACT NAME: _____

PHONE #: (____) _____ RELATIONSHIP: _____

FINANCIAL RESPONSIBILITY AGREEMENT STATEMENT

I understand that I/We are responsible for all charges even those not paid by insurance.

Should the services of an outside agency be required for collection of the account, I/We agree to pay costs of collections including but not limited to collection agency fees of 35%, Attorney's fees, Interest, and court costs.

Signature: _____ Date: _____

PATIENT HEALTH HISTORY

Patient name: _____ DOB ___/___/___ Gender: Male Female

Primary Care Physician: _____ Weight: _____ Height: _____

Do you currently wear Glasses ? YES / NO Do you wear contacts? YES / NO Do you wear drug store readers? YES / NO

Please indicate if any of the conditions apply to you or a family member (blood relatives only)

DISEASE/CONDITION FOR YOURSELF			DISEASE/CONDITION OF FAMILY MEMBER(S)		FAMILY MEMBER(S)
Eye Turn/Lazy Eye	YES	NO	Blindness	YES/NO	_____
Glaucoma	YES	NO	Eye Turn/Lazy Eye	YES/NO	_____
Macular Degeneration	YES	NO	Glaucoma	YES/NO	_____
Retinal Detachment	YES	NO	Macular Degeneration	YES/NO	_____
Dry Eyes	YES	NO	Retinal Detachment	YES/NO	_____
Cataract	YES	NO	Cataract	YES/NO	_____

Women: Are you pregnant? YES / NO Are you Breast Feeding? YES / NO

REVIEW OF SYSTEMS:

ALLERGIC/IMMUNOLOGICAL
- ☐ None
- ☐ Lupus (SLE)
- ☐ Rheumatoid Arthritis
- ☐ Fibromyalgia
- ☐ Crohn's

CARDIOVASCULAR
- ☐ None
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Stroke
- ☐ Vascular Disease

HEMATOLOGIC/LYMPHATIC
- ☐ None
- ☐ Leukemia
- ☐ Bleeding Disorder
- ☐ Cancer

SKIN
- ☐ None
- ☐ Acne
- ☐ Eczema
- ☐ Rosacea
- ☐ Psoriasis

ENDOCRINE/GLANDS
- ☐ None
- ☐ Diabetes – Insulin Dependent
- ☐ Diabetes – Non Insulin Dependent
- ☐ Thyroid Dysfunction
- ☐ Hormone Dysfunction

NEUROLOGICAL
- ☐ None
- ☐ Multiple Sclerosis
- ☐ Cystic Fibrosis
- ☐ Epilepsy
- ☐ Muscular Dystrophy

MUSCLE/SKELETAL
- ☐ None
- ☐ Arthritis
- ☐ Ankylosing Spondylitis
- ☐ Osteoporosis

RESPIRATORY
- ☐ None
- ☐ Asthma
- ☐ COPD
- ☐ Emphysema

GASTROINTERTINAL
- ☐ None
- ☐ Colitis
- ☐ Acid Reflux/Ulcer

PSYCHIATRIC
- ☐ None
- ☐ Depression
- ☐ Bi-Polar
- ☐ Schizophrenia

GENITAL/URINARY
- ☐ None
- ☐ HIV Positive
- ☐ Herpes
- ☐ Chlamydia

SOCIAL
Tobacco Use:
- ☐ Current Smoker
- ☐ Previous Smoker

List medications, including supplements and routine vitamins:

_____

_____

List ALL major surgeries, Eye surgeries, Kidney, Brain, Thyroid and Lung:

_____

Allergies: _____

Please sign below to acknowledge that this form is current and correct.

Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Russell P. Elliott, O.D. P.O. Box 565, 125 E Washington St., Greencastle, IN 46135 (765)653-3914
Compliance officer: Jane Bruner

YOU ARE ONLY REQUIRED TO SIGN THIS EVERY YEAR. We can decline to serve you, and MUST decline to file any insurance claims if you elect not to sign this form.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA) put forth by the U. S. Federal Government, I have certain right to privacy regarding my protected health information.

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, refer you to a mutually agreeable specialist, to obtain payment for our services, and to conduct health care operations involving our office. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among multiple healthcare providers who I agree may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers. (i.e. Government, Commercial or Private insurance companies).
- Conduct normal healthcare operations such as quality assessments, specialist referrals, and physician certifications.

I have read and understand your **Notice of Privacy Practices** containing a more complete and detailed description of the uses and disclosures of my health information. I understand that this organization has the right to change its **Notice of Privacy Practices** from time to time and that I may contact this organization, in writing, at any time at the address above; Attn: Compliance officer, to obtain a current copy of the **Notice of Privacy Practices**.

When I sign this document, I signify that I agree that this office can and will disclose my health information as listed. I can revoke this content in writing at any time unless this office has already treated me, sought payment for service rendered, or performed health care operations in reliance on your ability to use or disclose your health information in accordance with this notice. Our office can decline to serve you if you elect not to sign this form.

I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions until the agreed upon expiration date of such.

_____ _____

Patient name (printed) Patient or Representative Signature

Date: _____

***This form is effective continuously until such time that you revoke in writing, in person at this location.