

# 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 \_\_\_\_\_

# 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: M F

Primary Care Physician: \_\_\_\_\_ Date Last Seen by PCP: \_\_\_\_\_

**Medical/Family History** (use back sheet if more space is needed)

Please list all your current medications (include over the counter, vitamins and herbal therapy): \_\_\_\_\_

List all major surgeries (Eye Surgery included): \_\_\_\_\_

List allergic conditions :(e.g. medications, seasonal, mold, dust, latex, eye drops): \_\_\_\_\_

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

Disease/Condition	Yourself			Yes	No
	Yes	No			
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	Women are you Pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Eye Turn	<input type="checkbox"/>	<input type="checkbox"/>	Are you breast feeding?	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>			
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>			
Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>			

	Family Member		Relationship (Blood Relatives Only)
	Yes	No	
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye Turn	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>	_____

Other: \_\_\_\_\_

**Review of Systems**

Please indicate below if you have or ever had problems with the following conditions:

**Allergic/Immunologic**

- None
- Lupus (SLE)
- Rheumatoid Arthritis
- Environmental Allergies
- Other

**Cardiovascular**

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

**Hematologic/Lymphatic**

- None
- Anemia
- Leukemia
- Bleeding Disorder
- Other

**Ear, Nose and Throat**

- None
- Sinusitis
- Upper Respiratory Tract Infection
- Other

**Endocrine/Glands**

- None
- Diabetes
- Hormone Dysfunction
- Thyroid Dysfunction
- Other

**Neurological**

- None
- Multiple Sclerosis
- Epilepsy
- Tremors
- Other

**Gastrointestinal**

- None
- Crohn's Disease
- Colitis
- Acid Reflux/Ulcer
- Other

**Respiratory**

- None
- Asthma
- Bronchitis
- Emphysema
- Other

**General Health**

- None
- Weight loss/gain
- Fever
- Fatigue
- Trauma

**Skin**

- None
- Eczema
- Rosacea
- Psoriasis
- Other

**Muscle/Skeletal**

- None
- Arthritis
- Fibromyalgia
- Ankylosing Spondylitis
- Other

**Social**

- Tobacco Use: Current Smoker \_\_\_\_\_ Previous Smoker \_\_\_\_\_
- Non-Prescription Drugs \_\_\_\_\_
- Alcohol Consumption \_\_\_\_\_
- Weight \_\_\_\_\_ Height \_\_\_\_\_

**Psychiatric**

- None
- Depression
- Bi-Polar
- Schizophrenia
- Other

**Genital/Urinary**

- None
- Urinary Tract Infection
- HIV Positive
- Herpes/Chlamydia
- Other

Please sign below to acknowledge that this form is current:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Reviewed by Doctor's initials: \_\_\_\_\_

Do you currently wear glasses or contacts? \_\_\_\_\_

If not, do you wear drugstore readers? \_\_\_\_\_

**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 FORM 1 TIME. 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.