EYE CARE NORTHWEST PATIENT REGISTRATION

Referred by:_____ **Family doctor:**_____

Patient Name._____ Today's Date_____
Last First Middle

Home Address_____

City_____State_____ Zip Code_____

Home Phone_____Cell Phone_____

E-mail address_____ Marital Status Single Married Divorced Widowed

Social Security Number_____ Date of Birth_____ Age _____ Gender M F

Employer/Parent's Employer_____ Occupation_____

Work Address_____ Work Phone_____

City_____ State_____ Zip Code_____

Spouse name (Parent name if minor) _____Spouse/Parent Work Phone_____

Person to notify in case of emergency (other than spouse)_____

Phone number (s)_____ Relationship_____

Primary Insurance Company		
ID#	Group #	Effective Date
Subscriber Name		**Relationship to Patient**
Social Security Number	Date of Birth	Employer

Secondary Insurance Company		
ID#	Group #	Effective Date
Subscriber Name		**Relationship to Patient**
Social Security Number	Date of Birth	Employer

I certify that I (or my dependent) have insurance coverage as stated above and agree to have insurance payments made directly to (Practice Name) to be applied to my account for services rendered. I understand that I am financially responsible for all charges incurred in the event that my insurance denies payment. I am aware there may be additional collection and/or attorney's fees if my account is referred for collection. For patients covered by Medicare the patient will be responsible for 20% of the Medicare allowable charges plus any deductibles, coinsurance and uncovered charges that apply.

_____ _____

Patient's signature **Today's date**

EYE CARE NORTHWEST MEDICAL HISTORY QUESTIONNAIRE

CHART#_____

Name: _____ **Date of Birth:** _____ **Age:** _____ **Date:**_____

Height:____ Weight:____ Sex: M / F Primary Care Physician: Name_____ Phone_____

CONDITIONS:	Circle any and all conditions that apply to you or check none.	NONE
GENERAL:	fever, heat stroke, weight loss, weight gain, fatigue, insomnia, headaches	
EARS, NOSE, THROAT:	hard of hearing, ear ache, cough, dry mouth, sinus/allergy, hoarseness, vertigo	
CARDIOVASCULAR:	high B/P, heart attack, chest pain, congestive heart failure, racing pulse, high cholesterol, irregular heartbeat, palpitations, pace maker	
RESPIRATORY	congestion, wheezing, short of breath, asthma, COPD, emphysema, TB exposure	
GASTROINTESTINAL:	stomach upset, diarrhea, constipation, hernia, ulcers, nausea, GERD,	
GENITOURINARY:	painful/ frequent urination, impotence, yellow jaundice, kidney stones, blood in urine	
FEMALES:	Are you pregnant? Are you nursing?	
MUSCULOSKELETAL:	joint pain, stiffness, swelling, cramps, fibromyalgia, rheumatoid arthritis, lupus, other type arthritis, osteoporosis	
DERMATOLOGIC:	pimples, acne, warts, growths, rash, rosacea, melanoma	
NEUROLOGICAL:	numbness, headache, seizures, paralysis, stroke, dementia, memory loss, Alzheimer's, Parkinson's	
PSYCHIATRIC:	anxiety, depression,	
ENDOCRINE:	diabetes, hypothyroid, hyperthyroid, hormone, increased thirst , Graves Disease, Thyroid Eye Disease	
HEMATOLOGY:	bleeding, anemia, blood clots, problems related to blood transfusions,	
ALLERGIC/IMMUNOLOGIC:	sinus, sneezing, swelling, redness, itching, hives, lupus, HIV, Herpes Simplex Virus, Sjogren's Syndrome, rheumatoid arthritis,	
CANCER:	breast, prostate, lung skin, colon other	
EYES:	cataract, glaucoma, detached retina, blindness, lazy eye, eye injury/trauma, corneal problems, macular degeneration	

List all Eye Surgeries & Laser Eye Surgeries:

_____

_____

List all OTHER surgeries you have had:

_____

_____

FAMILY HISTORY: Has any member of your immediate family (blood relatives) have/had these diseases?

Disease/Condition			Family Member	Disease/Condition			Family Member
Lazy Eye	yes	no	Mother Father Sibling Grandparent	Heart Disease	yes	no	Mother Father Sibling Grandparent
Macular Degeneration	yes	no	Mother Father Sibling Grandparent	Hypertension	yes	no	Mother Father Sibling Grandparent
Blindness	yes	no	Mother Father Sibling Grandparent	Stroke	yes	no	Mother Father Sibling Grandparent
Retinal Disorders	yes	no	Mother Father Sibling Grandparent	Thyroid Disease	yes	no	Mother Father Sibling Grandparent
Cataracts	yes	no	Mother Father Sibling Grandparent	Arthritis	yes	no	Mother Father Sibling Grandparent
Glaucoma	yes	no	Mother Father Sibling Grandparent	Cancer	yes	no	Mother Father Sibling Grandparent
Diabetes	yes	no	Mother Father Sibling Grandparent	Type of Cancer: _____			Mother Father Sibling Grandparent

Physician Signature: _____ **Date:** _____

All information you provide is confidential and will not be released to anyone without your consent
Use back of form for any additional information that you need to add.

EYE CARE NORTHWEST   MEDICAL HISTORY QUESTIONNAIRE

CHART#____________

Patient Name:________________________________ **Date of Birth:**______________ **Date:**_____________

FAMILY MEDICAL HISTORY CONTINUED:

Is mother deceased? Y / N If yes- cause of death?_____________________

Is father deceased? Y / N If yes- cause of death?_____________________

SOCIAL HISTORY:

Recreational Activities and Hobbies:____

(**Circle:**) Student Homemaker Employed Retired (**Circle:**) Single Married Separated Divorced Widowed

Do you use Tobacco? Yes / No Cigarettes / Smokeless ____ # Packs/Times a Day ____# of Years

Do you use Alcohol? Yes / No Rarely Daily Weekly 1-2 drinks 2-4 drinks Other ________

Recreational Drugs? Yes / No Rarely Daily Weekly Type:____________________________

LIST ALLERGIES TO MEDICATIONS: ____________________ **REACTION/PROBLEM**____________________

____

Preferred Pharmacy:__________________**Location**____________________________**Phone:**______________

List all Prescriptions and Over the Counter medications you are taking: (Including Eye Drops)

If you have a list, please give to receptionist to copy in lieu of filling out form:

REVIEWED:

Medication Name	Dosage	Taken how often ? PRN= when needed	Route	Reason for taking	Currently Taking Yes	No	Staff	Date
		___ Times a day ___ or PRN	__ Oral __ Topical __ Injection					
		___ Times a day ___ or PRN	__ Oral __ Topical __ Injection					
		___ Times a day ___ or PRN	__ Oral __ Topical __ Injection					
		___ Times a day ___ or PRN	__ Oral __ Topical __ Injection					
		___ Times a day ___ or PRN	__ Oral __ Topical __ Injection					
		___ Times a day ___ or PRN	__ Oral __ Topical __ Injection					
		___ Times a day ___ or PRN	__ Oral __ Topical __ Injection					
		___ Times a day ___ or PRN	__ Oral __ Topical __ Injection					
		___ Times a day ___ or PRN	__ Oral __ Topical __ Injection					
		___ Times a day ___ or PRN	__ Oral __ Topical __ Injection					

Physician Signature:

Date:

All information you provide is confidential and will not be released to anyone without your consent

Use back of form for any additional information that you need to add.

AUTHORIZATION TO DISCLOSE MEDICAL RECORDS: CONTINUITY OF CARE

Patient Name: _____

Phone #: _____ DOB: _____

I authorize to release the following information to Karen Winchester, M.D., P.C.:

☐ Complete Medical Record

☐ Specific Information ONLY. Please include:

☐ Ophthalmology Chart Notes ☐ Spectacle/Contact Lens Measurements

☐ Visual Fields ☐ Records created _____ to _____ only.

☐ Other (please specify):

Please send my protected health information to Karen Winchester, M.D., P.C. at 7724 SW 31st Avenue, Portland, OR 97219-2420

Fax: (503) 232-0193

I understand additional laws require specific consent if my medical record contains any of the information listed below and that by initialing on the line corresponding to the record type I agree to have these types of records released, if they exist.

_____ Mental Health Information _____ Genetic Testing Information

_____ HIV/AIDS Information _____ Drug/Alcohol Diagnosis, Treatment or Referral

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer protected under federal law. However, I also understand that federal or state law may restrict redisclosure of drug/alcohol diagnosis, treatment or referral information, mental health information and genetic testing information.

Refusal to sign this authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign will mean you will not receive health care services is if the health services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure. You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. Any use or disclosure already made with your permission cannot be undone.

I have read this authorization and understand it.

_____ _____

Signature of Patient or Legal Representative Relationship to Patient

Date _____

Unless revoked, this authorization expires in 24 months or shall remain in effect for a period of time reasonably needed to effect the purpose for which it was gained.