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 numbers(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

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#*___________

Physician Signature: ____ **Date:** ______________

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:** ____________

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

AUTHORIZATION TO RECEIVE/RELEASE HEALTH INFORMATION

Due to the **HIPAA Compliance Privacy Laws of the Federal Government**, it is mandatory that we ask you to review and answer the following questions listed below.

Name: _____

May we leave messages/detailed medical information on voicemail at either of these phone numbers?

☐ Yes ☐ No Home Phone: _____ ☐ Yes ☐ No Cell Phone: _____

May we contact you at your place of employment? ☐ Yes ☐ No
If so, may we leave a message? ☐ Yes ☐ No

If yes: Work Phone: _____ Extension: _____

Do you have any particular person or family members that you authorize to receive and discuss information regarding your personal health information (general information, surgical and billing)?

☐ Yes ☐ No If yes, please provide:

Name: _____ Relationship: _____

Phone Number: _____ Alternate Number: _____
Is this person your Power of Attorney for medical purposes? ☐ Yes ☐ No

Name: _____ Relationship: _____

Phone Number: _____ Alternate Number: _____

I hereby authorize Karen Winchester MD, to obtain or release any and all pertinent information regarding my medical care, as needed, to assist in my ongoing treatment to or from other health care providers, laboratories, radiology facilities or other institutions. **This authorization remains in effect until revoked.**

I have reviewed the aforementioned information and provide my consent regarding any and all the issues as stated above.

I have reviewed Notice of HIPAA Privacy Policy. A copy of this policy will be provided to me upon request.

Patient Signature: _____ **Date:** _____

WITNESSED BY: _____