Patient Registration Form

Please use Black Ink only to fill out forms.

☐ Please check this box if you are a winter visitor. If so, please provide both addresses.

☐Mr. ☐Mrs. ☐MS. ☐Dr. ☐Male ☐Female

LEGAL Name: ______________________________
Last *First* *MI*

Your Home Phone: ____________ Cell Phone: ____________

Alternate Phone: ____________ ☐ *Work* ☐ *Day* ☐ *Other*

Marital Status: ____________ Spouse's Name: ____________

Age: ______ Date of Birth ____/____/____ Social Security # ____________

Local Address: ______________________________
Street Apt# City State ***9 DIGIT ZIP***

Mailing Address: ______________________________
Street *Apt#* *City* *State* ***9 DIGIT ZIP***

Employer Name & Address: ______________________________
____

Occupation: ______________________________

Reason for Today's Visit: ______________________________

RACE: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Unknown ☐ Other ____________ ☐ Refuse

PRIMARY LANGUAGE ☐English ☐Spanish ☐Other Not Specified ____________ ☐ Refuse

ETHNICITY: ☐ Hispanic or Latino ☐ Non-Hispanic or Non-Latino ☐ Unknown ☐ Refuse

MEDICAL INFORMATION:

Who is your Medical Doctor? ______________________________

Address: ______________________________ Phone ____________

E-MAIL ADDRESS: ______________________________

We do NOT share this information with <u>anyone</u>. E-mail is a way for your doctor to communicate with you, to receive information about your procedure and to send reminders

How would you prefer for us to communicate with you?

☐ Phone (○ home ○ cell ○ alternate) ☐ E-Mail

RESPONSIBLE PARTY: ______________________________

D.O.B *(of responsible party)* ______________________________

Phone: ____________ Relationship ____________

Emergency Contact: ____________ Phone: ____________
(Not in the same household)

Form continues → → → →

PATIENT HISTORY

Thank you for completing this form. This information will assist the doctors and staff in providing quality care.

Please use Black Ink ONLY when filling out these forms.

Patient Name: ____________________ (Please print.) Date: __________

Ht. ________ Wt. ________ Age ________ DOB ________ Gender: ❑ M ❑ F

Are you pregnant? ❑ Yes ❑ No

MEDICAL HISTORY: Have you or a family member had, or do you currently have any of the following?

Systemic	Self	Family	If family, who?
Anemia	❑ Yes	❑ Yes	
Bleeding Disorders	❑ Yes	❑ Yes	
Sickle Cell	❑ Yes	❑ Yes	
Clotting Disorders	❑ Yes	❑ Yes	
Arthritis	❑ Yes	❑ Yes	
Diabetes	❑ Yes	❑ Yes	
Thyroid	❑ Yes	❑ Yes	
Autoimmune Disorders	❑ Yes	❑ Yes	
Fibromyalgia	❑ Yes	❑ Yes	
Systemic Connective Tissue Diseases	❑ Yes	❑ Yes	
Dermatitis / Eczema	❑ Yes	❑ Yes	

Lung	Self	Family	If family, who?
Asthma	❑ Yes	❑ Yes	
Emphysema	❑ Yes	❑ Yes	
Bronchitis	❑ Yes	❑ Yes	
Pneumonia	❑ Yes	❑ Yes	

Vascular	Self	Family	If family, who?
Congestive Heart Failure	❑ Yes	❑ Yes	
Heart Attack	❑ Yes	❑ Yes	
Heart Disease	❑ Yes	❑ Yes	
High Cholesterol	❑ Yes	❑ Yes	
High Blood Pressure	❑ Yes	❑ Yes	
Stroke	❑ Yes	❑ Yes	
Pacemaker	❑ Yes	❑ Yes	
Defibrillator	❑ Yes	❑ Yes	

Other	Self	Family	If family, who?
Hepatitis	❑ Yes	❑ Yes	
HIV / AIDS	❑ Yes	❑ Yes	
Seizures	❑ Yes	❑ Yes	
Herpes:			
a) Cold sores	❑ Yes	❑ Yes	
b) Shingles	❑ Yes	❑ Yes	
c) Other	❑ Yes	❑ Yes	

OCULAR HISTORY ***Do you wear: ❑ Glasses ❑ Contact Lenses ❑ OTC Reading Glasses***

Date of Last Exam:

	Self	Family	If family, who?
Keratoconus	❑ Yes	❑ Yes	
Amblyopia / Strabismus	❑ Yes	❑ Yes	
Blindness	❑ Yes	❑ Yes	
Cataract	❑ Yes	❑ Yes	
Glaucoma	❑ Yes	❑ Yes	
Macular Degeneration	❑ Yes	❑ Yes	
Retinal Detachment	❑ Yes		
Eye Injury / Trauma	❑ Yes		
Past RK, PRK or LASIK	❑ Yes		
Eye or Lid surgery	❑ Yes		
Dry Eye Syndrome	❑ Yes		
Eye Allergies	❑ Yes		

Form continues → → →

Patient Name: ______________________ Date: ______________
(Please print.)

Are you currently taking long-term corticosteroids? ❑ Yes ❑ No
Any other diseases, conditions or problems we should know about? ______________

SURGERY HISTORY: List ALL prior eye surgeries and major surgical procedures and year

MEDICATIONS List all medications that you are currently taking, including over-the-counter medicines or remedies

Drug Name	Strength	How often used	Drug Name	Strength	How often used

List all medication, food and other items that you are allergic to. If you have no allergies, write "NONE".

ALLERGIES	REACTION

Are you sensitive to iodine / tape / latex? ❑ Yes ❑ No
If you had an allergic reaction, did you have:
Skin rash or hives? ❍ Yes ❍ No
Wheezing or trouble breathing? ❍ Yes ❍ No
Hay fever or runny nose? ❍ Yes ❍ No

SOCIAL HISTORY:
Do you use tobacco? ❑ Yes ❑ No Usage per day? ______ How many years? ____
If you quit, when? ______
Alcoholic beverage use? ❑ Yes ❑ No How much? ____ How often? ____ How many years? ____
Caffeine use? ❑ Yes ❑ No How much? ____ per day?
Recreational drug use? ❑ Yes ❑ No *❍ Current or ❍ Former* Name of drug(s) ______

PATIENT SIGNATURE	DATE	STAFF SIGNATURE	DATE / TIME

Acknowledgment of Receipt of Privacy Notice and/or Summary of HIPAA Changes

I hereby acknowledge that I have been presented with a copy of the Total Eyecare Centers Notice of Privacy Practices and/or the HIPAA Final Rule 2013 Summary of Key Changes.

______________________________	______________________________
Signature of Patient or Responsible Party	Date
______________________________	______________________________
Printed Name of Patient	Patient DOB

Individuals we may give health information to:

Name *(Please print)*	**Relationship**
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

Stipulation Request:

____

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______________________________	______________________________
Signature of Patient or Responsible Party	Date

AN IMPORTANT ANNOUNCEMENT FROM OUR DOCTORS

SanTan EyeCare Commitment is to offer all patients the highest standard of care available today. Standard of care, in terms of examination of your retina, is a dilated retinal examination. Your eye's retina is responsible for receiving light and triggering the processes that lead to vision. A retinal evaluation provides insight into your retinal health and is, therefore, an essential element of your eye examination. Along with aiding detection of retinal diseases like macular degeneration, retinal detachments and glaucoma, it can also detect ocular effects of systemic disease such as diabetes and high blood pressure. Because of these facts, the doctors at Total EyeCare Centers are recommending EITHER a dilated examination or an Optomap on all patients. After reading descriptions of both procedures, you will be given the opportunity to choose one or opt-out of both with a signature below.

DILATION: Looking into the eye without dilation is analogous to looking into a room "through the keyhole" in a door. Enlarging the pupils with eye drops in essence, "opens the door" and allows the doctors a better view of the retina and other internal structures. Dilation causes sensitivity to light and may blur your vision (for 3-5 hours). The amount of blur is dependent on your age, prescription and drops used. Dilation is a safe and common procedure used every day in clinics all over the world. We can perform the dilation today (preferred) or reschedule the procedure if the visual side-effects will cause a hardship at work, school or other planned activities.

OPTOMAP: The Panoramic200 scanning laser ophthalmoscope captures a computerized digital map of your retina. This image gives our doctors the ability to view multiple retinal layers and show you your images TODAY during your examination. This gives us the ability to track and compare images from year to year. It is fast and non-invasive, with no after-effects (because no drops are used). Most vision plans cover a basic eye examination and will not provide coverage for advanced screening tests. The fee for the OPTOMAP is only ~~$40~~ ($35 after a prompt-pay courtesy). $29.75 We feel the information and documentation attained, along with the lack of visual effects arising from pupillary dilation, is well worth the additional fee for this revolutionary new technology.

NOTE: DEPENDING ON YOUR CONDITION, A SMALL PERCENTAGE OF PATIENTS MAY STILL NEED TO BE DILATED EVEN IF THEY CHOOSE THE OPTOMAP. YOUR DOCTOR WILL ADVISE YOU ACCORDINGLY.

Please check one of the options below:

I elect dilation ______

I elect to have an Optomap ______

I decline both dilation and Optomap ______

I understand that the doctor recommends these procedures as appropriate for me to have and if I elect to decline both procedures my doctor will not be able to adequately check for the presence of retinal pathology, optic nerve disease or the other anomalies such as those described above.

Patient Name (please print)________________________________

Patient (or responsible party) Signature__________________________ Date__________