Internal Use Only √ In by: _____
Ins Card Needed: X- Yes
√ Out: _____ Scanned:_____

Patient Registration and Health History

Last Name:_____ **First Name**:_____ **MI**:_____ **Date**: _____

Preferred Name/Nick Name:_____ **Title**: Dr Mr Mrs Miss Other_____

Sex: Male/Female **Birthdate**: _____ **Age**:_____ **Last 4 SSN**: _____

Mailing Address: _____ **City**: _____ **State**: _____ **Zip**: _____

Home Phone: (_____)_____ **Work**:(_____)_____X:_____ **Cell**:(_____)_____

Email Address: _____ **Preferred phone**: Home ph / Work ph / Cell ph

Marital Status: Married / Single / Widowed / Other **Partners Name**: _____

Preferred Language: English / Spanish / Other _____ **Height** _____ **Weight**_____

Race: Am Indian / Asian / Black or African Am / Hispanic / White / Other _____ **Ethnicity**: Hispanic / Non Hispanic

Employer: _____ **Occupation**: _____

Employment: Full Time / Part Time / Retired / Unemployed / Other **Student**: Full Time / Part Time **Level**:_____

Insurance Company(ies)_____ ***(Please present your card(s) so we can make a copy)***

Who is responsible for outstanding charges on this Account (copays, etc)? Self / Other ***(***fill in information below ***if other)***

Name: _____ **Relationship**: _____ **DOB**: _____

Address: _____ **City**: _____ **State**:_____ **Zip**: _____

Notice of Privacy Practice

I authorize the release of any medical or other information necessary to process insurance. I authorize payment of benefits to Robeson Family Vision Center. I understand that if services, materials and/or any collection cost are not covered I will be responsible for charges incurred.

I understand that there will be finance charges on all past due accounts over 30 days.

I acknowledge that I have had the opportunity to review and have been offered a copy of **Robeson Family Vision Center's Notice of Privacy Practice**.

_____ _____

Signature of patient or responsible party **Date**

Reason for today's exam? _____ Referred here by:_____

Are you planning to get new glasses today? Yes / No Last Exam: ____/____/____ Examining Dr/Facility: _____

Do you ***currently*** have any problems in the following areas?								
Dryness*	Y	N	Mucous Discharge*	Y	N	Infection of Eye	Y	N
Sandy or Gritty Feeling*	Y	N	Itching	Y	N	Drooping Eyelid	Y	N
Fluctuating Vision*	Y	N	Blurred Vision	Y	N	Crossed Eye/Lazy	Y	N
Burning*	Y	N	Night Vision Troubles	Y	N	Loss of Side Vision	Y	N
Excess Tearing*	Y	N	Glare/Light Sensitivity	Y	N	Headaches	Y	N
Foreign Body Sensation*	Y	N	Loss of Vision	Y	N	See Floaters/Spots	Y	N
Tired Eyes*	Y	N	Double Vision	Y	N	See Flashing Light	Y	N
Contact Discomfort*	Y	N						

Have you ever been diagnosed with the following:

Cataracts: **YES / NO** *When*? _____Glaucoma: **YES / NO** *When*?_____ Macular Degeneration? **YES / NO** *When*?_____

Do you wear contact lenses? **YES / NO** *Type*?:_____ *If No, Are you interested in wearing contact lenses*? **YES / NO**

Does your vision limit any activities of daily living (driving, reading, sports, computer, work etc,)? **YES** **NO**

Would you like more information about any of the following: *UV eye damage?* **YES / NO** *Macular degeneration*? **YES / NO**

Cataracts? **YES / NO** *Glaucoma*? **YES / NO** *LASIK/Refractive Surgery*: **YES / NO**

List any **MEDICATIONS** you currently take (Rx and over-the-counter)_____

Do you have **ALLERGIES** to any medications or other allergies (i.e. outdoor, bees etc) ? **YES / NO** *Please list*:_____

List all **Major Illnesses**: (diabetes, high blood pressure, heart attack, stroke, etc): _____

Do you *currently* have any problems in the following areas?					
General/Constitutional (fever, heat stroke, weight loss/gain)	Y	N	**Muscles, bones, joints** (joint pain, stiffness, swelling,, cramps, arthritis etc)	Y	N
Ears, Nose, Throat (hard of hearing, stuffy nose, ear ache, cough, dry mouth)	Y	N	**Skin** (pimples, warts, growths, rash etc)	Y	N
Cardiovascular (high BP, racing pulse etc)	Y	N	**Neurological** (numbness, headaches, seizures, paralysis, etc)	Y	N
Respiratory (congestion, wheezing, short of breath, emphysema etc)	Y	N	**Psychiatric** (anxiety, depression, insomnia etc)	Y	N
Gastrointestional (stomach upset, diarrhea, constipation, ulcers, hernia etc)	Y	N	**Endocrine** (diabetes, hypothyroid etc)	Y	N
Genital, kidney, bladder (frequent/painful urination, jaundice, etc)	Y	N	**Blood Lymph** (bleeding, high cholesterol, anemia, etc)	Y	N
Females Are you pregnant? Nursing? Or Taking Birth Control?	Y	N	**Allergic/Immunologic** (sneezing, redness, itching, hives, lupus etc)	Y	N

Has any member of your IMMEDIATE family (Father (F), Mother (M), Brother (B), Sister (S) had the following diseases:

Diabetes:_____ Hypertension:_____ Thyroid:_____ Cataract:_____ Glaucoma: _____ Macular Degeneration: _____

Other heritable disease: _____

Do you drink alcohol? **YES / NO** *How much*? _____

Do you use ANY tobacco products? **YES / NO** *How much*?_____ *How many years*? _____

Scanned:_____

VISION SOURCE

If you do not wish to receive text message or email notifications please VERBALLY notify a staff member so we may modify your file. Our contact system no longer makes automated phone calls if we have an email or cell phone on file.

Notice of Privacy Practices

In signing this authorization to release my protected health information, I acknowledge that I understand my right to medical information confidentiality and authorize Robeson Family Vision Center to discuss all my medical health information with the individual(s) listed below:

Name_____ Relationship_____

Name_____ Relationship_____

☐ I do not wish to share any of my information with any other individuals

EyeScreen Photo Examination

Our doctors recommend the EyeScreen Examination for all patients and will perform the EyeScreen Exam at an additional cost of $34.00 due today. The Eyescreen is not covered by insurance nor will it be submitted to insurance

EyeScreen is a high resolution screening photograph of your retina which will help us document, review, and compare your retina over time. If you require additional information, please inquire at the front desk.

☐ **I AGREE TO** have my retinal health evaluated with the EyeScreen Exam and I know I will be responsible for the $34.00 today. (The Eyescreen it not covered by insurance nor will it be submitted to insurance).

☐ **I DO NOT** wish to have the EyeScreen Exam and ***I wish to be dilated today***

☐ **I DECLINE** both EyeScreen AND dilation. I understand that this means the doctor will not get a complete view of the health of my eye

SIGN HERE

Patient Printed Name | Patient/Guardian Signature | Date

*By signing this page you acknowledge both the “Notice of Privacy Practices” and the “Eyescreen Photo Examination” consents