Patient Registration and Health History

Date: _____

Legal Last Name:_____ **Legal First Name**:_____ **MI**:_____

Preferred Name:_____ **Title**: Dr / Mr / Mrs / Miss / Mx **Gender Identity**: She-Her / He-Him / They-Them

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

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

Landline: (_____)_____ **Work**:(_____)_____X:_____ **Cell**:(_____)_____

Email Address: _____ **Preferred phone**: Landline / 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 Finance, Privacy and Prescription Practices

1) 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.

2) 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 Practices.

3) I understand that my protected medical information may be released to the above-named responsible party if necessary to process insurance

4) I understand and accept that upon successful completion of my refractive eye examination and/or contact lens fitting process my eyeglass and/or contact lens prescriptions will be provided electronically through the PHR (Personal Health Record)

I understand these authorizations remain in place for the duration of my care and must be cancelled in writing.

_____ _____

Signature of patient or responsible party **Date**

Internal Use Only
Verbally Ask: DFE ok? Yes / No
Eyescreen: Yes / No / Talk to Dr

Internal Use Only
√ In by: _____ Scanned: Yes / No
Ins Card Rcvd: Yes / No / Will Send
√ Out: _____

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*? _____

AUTHORIZATION FOR DISCLOSURE OF PATIENT HEALTH CARE INFORMATION

I, _____ / _____
NAME OF PATIENT DATE OF BIRTH

AUTHORIZE:

Robeson Family Vision Center
1400 Homer Road
Winona, MN 55987

TO DISCLOSE MY INFORMATION TO THE FOLLOWING INDIVIDUALS

1._____ Relationship: Spouse / Child / Caregiver / Other

2. _____ Relationship: Spouse / Child / Caregiver / Other

3. _____ Relationship: Spouse / Child / Caregiver / Other

The above-named individuals are entitled to receive information concerning my healthcare records as well as conduct business with Robeson Family Vision Center regarding any and all dealings I may have with Robeson Family Vision Center. This agreement can only be cancelled in writing.

_____ _____
PATIENT SIGNATURE/ PARENT OR LEGAL GUARDIAN DATE