

NEW PATIENT REGISTRATION

DATE _____

Patient Name _____ Sex M ___ F ___ Birthdate _____ Age _____
 Nickname _____ Name of spouse or guardian _____
 Address _____ City _____ State _____ Zip _____
 Home Phone # _____ Work Phone # _____ Mobile Phone # _____
 Occupation (self/parents) _____ Employer _____
 Sports/Hobbies _____ Employment Status: FT ___ PT ___ Retired ___
 Responsible Party _____ Responsible Party SS# _____
 Responsible Party Drivers License # _____ Exp. _____ Patients SS# _____ (for ins. purposes)
 Other family members living at home:
 Name _____ Age _____ Name _____ Age _____
 Name _____ Age _____ Name _____ Age _____

Reason for this appointment (routine, eye irritation, supply of contacts, lost glasses, etc) _____

DO YOU OR ANY FAMILY MEMBER HAVE OR EVER HAD: S= SELF F=FAMILY

<input type="checkbox"/> Near vision blurred	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Heart/ Vascular disorders
<input type="checkbox"/> Distance vision blurred	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> High/Low blood pressure
<input type="checkbox"/> Redness, Itching or burning	<input type="checkbox"/> Blindness	<input type="checkbox"/> High/Low blood sugar
<input type="checkbox"/> Eye turn/lazy eye	<input type="checkbox"/> Eye surgery	<input type="checkbox"/> Thyroid problems
<input type="checkbox"/> Double vision	<input type="checkbox"/> Lasik/PRK surgery	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Color Blindness	<input type="checkbox"/> Hearing problems	<input type="checkbox"/> Women: currently pregnant?
<input type="checkbox"/> Retinal diseases	<input type="checkbox"/> Vision training/eye exercises	<input type="checkbox"/> Headaches
<input type="checkbox"/> Head/eye injury	<input type="checkbox"/> Fainting/ dizziness	
<input type="checkbox"/> Allergies (list medications) _____		
<input type="checkbox"/> Flashes, floaters, spots	<input type="checkbox"/> Sudden vision loss	_____

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE VITAMINS, BIRTH CONTROL PILLS, ETC):

Date of Last Eye Exam _____ Last Eye Doctor _____
 Date of Last Physical Exam _____ Physician Name _____
 Are you wearing contact lenses? _____ Brand and type (soft or rigid) _____
 Type of disinfection _____ Average # hours of daily wear _____ Do you sleep in contacts? _____
 Are you interested in contact lenses? _____ Are you interested in vision correction surgery information ? _____
 Whom may we thank for referring you? (Friend, sign, yellow pages, etc) _____

Vision Insurance Company _____ ID # _____
 Employer _____ Policy # _____

Major Medical Insurance Company _____ ID # _____
 Employer _____ Policy # _____

Medicare Supplement _____ ID # _____

Professional services are due at the time the services are rendered. A \$25 returned check fee will apply.

I understand that I am financially responsible for any charges not covered by insurance. _____ **Please initial**

DILATION CONSENT

Dilation is important for the inspection of the periphery of the eye for the presence of tumors, retinal detachments and other conditions such as floaters, flashes or spots appearing suddenly in the vision. The need to record the use of dilating agents has become a standard on determining the thoroughness of the examination. Some vision care plans do not cover this service. Please consult the front desk if you have any questions concerning this fee. **Note:** Due to the widening of the pupil, dilation will affect the comfort of many patients when reading and create light sensitivity, usually lasting approximately 4-6 hours, but may last overnight.

CHECK AND SIGN : _____ I accept Dilation _____ I decline Dilation

(OVER---)

PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment or health care operations.

As our patient we want you to know that we respect the privacy of your personal vision records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide healthcare that is in your best interest.

We also want you to know that we support your full access to your personal vision records. We may have indirect treatment relationships with you (such as laboratories that only interact with doctors and not patients), and may have to disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name: _____ Signature _____ Date _____

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation any money. We want you to know that our doctor and all of our employees and managers continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPPA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients. It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI. We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly. Thank you for being one of our highly valued patients.

MEDICARE PATIENTS ONLY **PLEASE READ STATEMENT BELOW**

I request that payment of authorized Medicare benefits be made to Dr. Bradley W Fielding on my behalf. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

SIGNATURE OF PATIENT OR AUTHORIZED AGENT

X _____