# WELCOME TO NORTHERN AVENUE EYE CARE

**PATIENTS NAME: _____ SEX: M / F DATE OF BIRTH ___/___/____**

**ADDRESS: _____ CITY _____STATE ____ ZIP _____**

**PHONE: CELL (____)_____ TEXT? Y / N HOME: (____)_____ Y / N WORK (____)_____**

**E-MAIL: _____ OCCUPATION: _____ SPOUSE OR PARENT'S NAME _____**

**VISION INSURANCE? Y / N NAME: _____ MEDICAL INSURANCE? Y / N NAME _____**

**NAME OF PRIMARY INSURED _____ DATE OF BIRTH ___/___/____ ID# _____**

**I request that payment of authorized insurance benefits be made on my behalf to Northern Avenue Eye Care for any services furnished. If my insurance carrier denies payment, I understand that I will be responsible for the balance on my account.**

**SIGNATURE: _____ DATE: ___/___/____**

## CHIEF COMPLAINT:

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## MEDICAL HISTORY:

**Do you currently wear glasses? Yes / No Do you currently wear contacts Yes / No**

**When was your last eye exam? _____ Location: _____**

**Please circle "S" for self or "F" for family member**

### Ocular History

| | | |
|---|---|---|
| Amblyopia (Lazy Eye) | S | F |
| Blindness | S | F |
| Cataracts | S | F |
| Glaucoma | S | F |
| Macular Degeneration | S | F |
| Flashes / Floaters | S | F |
| Retinal Detachment | S | F |
| Retinal Tear (Hole) | S | F |
| Eye Infections / Ulcers | S | F |
| Eye Surgery / Injury | S | F |
| Strabismus | S | F |
| NONE | S | F |

### Medical History

| | | |
|---|---|---|
| Allergies | S | F |
| Cancer / Tumors | S | F |
| Diabetes | S | F |
| Arthritis | S | F |
| High Blood Pressure | S | F |
| High Cholesterol | S | F |
| Heart Problems | S | F |
| Thyroid Problems | S | F |
| Sinus Problems | S | F |
| Lupus | S | F |
| Headaches | S | F |
| Pregnant | S | F |
| NONE | S | F |

**Do You Smoke: Yes / No If yes, frequency: _____**

**List all MEDICATIONS you are currently taking: _____**

_____

**Do you have any allergies to medications? List all that apply or write NONE:**

_____

**I certify the medical information provided is as current and accurate as possible.**

**Patient or Guardian Signature: _____Date: _____**

**Guardian printed name: _____**

# Protected Health Information

**Patient's Name: _____Date of Birth _____**

**I authorize the following person(s) to receive Protected Health Information (PHI) pertaining to my medical care other than myself or any Physician involved in my care:**

**Name: _____Relationship: _____**

**Name: _____Relationship: _____**

**<u>Restriction of Protected Health Information – Extremely important information:</u>**

**If there is someone, such as a parent, that is restricted from receiving PHI information pertaining to a patient that is a minor, a HIPAA Form F must be filled out along with a copy of the legal documentation to support the restriction to the records. The HIPAA Form F and legal documentation must be sent to our HIPAA Compliance Officer. If you need to complete this form, please have the Manager assist you with this request.**

**If there is NO restriction to access (see paragraph above), please initial: _____**

**I acknowledge that I have read and/or received a copy of the Notice of Privacy Practices and Conditions of Service. Initials:_____**

_____ _____

**Signature of Patient/Parent or Personal Representative** **Date signed**

_____ _____

**Print name of Patient/Parent or Personal Representative** **Relationship to patient**