**NORMAN EYE ASSOCIATES, P.C.**

**PATIENT REGISTRATION AND MEDICAL HISTORY**

Today’s Date

Patient’s Name

Address

City State Zip

Home Phone Work Phone Cell Phone

E-mail address

Date of Birth Social Security No. Sex M F

Place of Employment

Marital Status Spouse’s Name Ph #

If minor, Parent Name Ph #

Person responsible for account Relationship

Address (if different from patient) Ph #

**INSURANCE INFORMATION**

Indicate **Vision** Insurance if any: VSP/*some* Metlife Eyemed Access/Insight VCD PVCS VBA NRH WebTPA

Other [We do **not** take: UHC/Spectera, EM Select/Advantage, Davis/FEP Blue Vision, Superior, etc]

Member’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB ID or SS#

**Second** **Vision** Plan

Member’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB ID or SS#

**Primary** **Health/Medical** Insurance ID #

Member’s Name DOB Relationship

**Secondary** **Health/Medical** Insurance ID #

Member’s Name DOB Relationship

**GETTING TO KNOW YOU**

Whom may we thank for referring you to our office?

Is another family member a patient in our office?

Contact person and phone number in case of emergency

**EYE/HEALTH HISTORY**

Date of Last Eye Exam Dilated? \_\_\_ Yes \_\_\_No

Currently Wear Glasses? \_\_\_Yes \_\_\_No If yes, for what activity?

Currently Wear Contacts? \_\_\_Yes \_\_\_No If yes, brand/type

Reason for Today’s Visit

Have you or your parents, grandparents, or siblings experienced, or been treated for, any of the following? Check all that apply.

|  |  |  |
| --- | --- | --- |
| Cataracts (removed\_\_\_) | yourself | family member (who) |
| Crossed Eye | yourself | family member (who) |
| Glaucoma | yourself | family member (who) |
| LASIK or PRK | yourself | family member (who) |
| Lazy Eye | yourself | family member (who) |
| Macular Degeneration | yourself | family member (who) |
| Retinal Detachment | yourself | family member (who) |
| Prosthetic Eye | yourself | family member (who) |

Are you currently experiencing, or have experienced, any of the following? Check all that apply.

* Blurry vision: \_\_*near \_\_distance \_\_both*
* Burning
* Discharge
* Double vision or shadowing
* Dryness
* Excess tearing/watering
* Eye infection
* Eye pain or soreness
* Floaters or spots
* Halos
* Headaches
* Itching
* Light flashes
* Light sensitivity
* Redness
* Sandy or gritty feeling

Have you or a family member experienced, or been treated for, any of the following? Check all that apply.

|  |  |  |
| --- | --- | --- |
| AIDS/HIV | yourself | family (who) |
| Allergies | yourself | family (who) |
| Arthritis (rheumatoid\_\_\_\_) | yourself | family (who) |
| Asthma | yourself | family (who) |
| Blood/lymph disorder | yourself | family (who) |
| Cancer | yourself | family (who) |
| Diabetes | yourself | family (who) |
| Ears, nose, throat conditions | yourself | family (who) |
| Gastrointestinal conditions | yourself | family (who) |
| Heart disease | yourself | family (who) |
| High blood pressure | yourself | family (who) |
| High cholesterol | yourself | family (who) |
| Kidney disease | yourself | family (who) |
| Lupus | yourself | family (who) |
| Neurological conditions | yourself | family (who) |
| Psychiatric disorder | yourself | family (who) |
| Seizures | yourself | family (who) |
| Skin conditions | yourself | family (who) |
| Stroke | yourself | family (who) |
| Thyroid dysfunction | yourself | family (who) |

**Current Medications**, including homeopathic remedies, birth control pills, and over-the-counter meds: (or attach a list)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Medication Drug Allergies:

(Women) Are you currently pregnant or nursing?\_\_\_ Yes \_\_\_No

Family Physician Phone #

Endocrinologist if applicable Phone #

Rheumatologist if applicable Phone#

**HIPAA**

I acknowledge the opportunity to review or request the Notice of Privacy Practices. I give consent to disclose protected health information to carry out health operations, treatment, and payment.

**INSURANCE ASSIGNMENT AND RELEASE**

I certify that I/my minor child is covered by (name of insurance company)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 and assign directly to Norman Eye Associates/Dr. Geurkink all insurance benefits, if any, for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. I understand that with the many different insurance companies and plans, Dr. Geurkink may not be participating in my particular plan.

**FINANCIAL AGREEMENT**

I understand it is customary to pay for professional services at the time they are rendered unless other arrangements are made. When materials are required, half of the fee is expected on ordering. The balance is due upon dispensing.

I agree that I am responsible for all fees and services rendered for examination/treatment of myself/my minor child. I accept full financial responsibility for all charges for services or items provided to me or the patient.

Although I may have insurance coverage, I understand and agree to be responsible for all fees billed to my insurance company should payment be declined.

To the best of my knowledge, the information provided on this form is complete and correct.

Signed (patient/guardian) Date