PATIENT INFORMATION

PATIENT NAME: _____ **BIRTHDATE:** _____ **SEX: M F**
LAST FIRST MI

STREET ADDRESS: _____ **CITY:** _____ **ST:** _____ **ZIP:** _____

HOME PHONE: _____ **DAYTIME:** _____ **CELL:** _____ **MAY WE TEXT YOU? Y N**

MARITAL STATUS: _____ **SS#:**_____ ____ **E-MAIL ADDRESS:** _____

EMPLOYMENT STATUS: FULL-TIME PART-TIME STUDENT NOT EMPLOYED RETIRED

OCCUPATION: _____ **EMPLOYER:** _____

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PRIMARY HEALTH INSURANCE: _____ **SECONDARY HEALTH INSURANCE:** _____

VISION PLAN: _____

RESPONSIBLE PARTY (IF MINOR OR PRIMARY ON INSURANCE PLAN): _____
LAST FIRST MI

STREET ADDRESS: _____ ***CITY:*** _____ ***ST:*** _____ ***ZIP:*** _____

HOME PHONE: _____ ***DAYTIME:*** _____ ***CELL:*** _____

BIRTHDATE: _____ ***RELATIONSHIP:*** _____ ***LAST 4 DIGITS OF SS#:*** _____

HOW DID YOU LEARN ABOUT OUR PRACTICE? _____
INSURANCE ADVERTISEMENT INTERNET REFERRAL

WHO REFERRED YOU TO OUR PRACTICE? _____
RELATIVE FRIEND CO-WORKER DOCTOR NONE

PREVIOUS EYE DOCTOR_____ **LAST EYE EXAMINATION**_____

DO YOU WEAR GLASSES: YES NO WERE GLASSES PURCHASED AT THIS LOCATION? YES NO

CONTACT LENSES: _____ SOFT (BRAND: _____) _____ GAS PERMEABLE _____NO LONGER WEARING

HOW MANY YEARS WEARING CONTACTS? _____ HOW OFTEN DO YOU REPLACE YOUR CONTACTS?_____

MAX # OF HOURS WEARING IN A DAY?_____**HOURS WEARING TODAY?**_____**IF(0) LAST TIME YOU WORE**_____

BRAND OF MULTIPURPOSE SOLUTION? _____ **DO YOU USE DROPS FOR DRYNESS? YES NO**

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THE FOLLOWING INFORMATION IS REQUESTED IN COMPLIANCE WITH THE HITECH ACT:

RACE: _____ **PREFERRED LANGUAGE:** _____

ETHNICITY: _____ **PREFERRED METHOD OF COMM: PHONE MAIL EMAIL TEXT**

PATIENT HEALTH HISTORY **PATIENT NAME: _____**

FAMILY DOCTOR/PRACTICE: _____DR's PHONE: _____ DATE OF LAST PHYSICAL: _____

Medical/Family History (use back of sheet if more space is needed)

Please list **ALL** your current medications (include over the counter, vitamins and herbal therapy):

_____

_____

List **ALL MEDICATION ALLERGIES**/reactions: _____

List **ALL NON MEDICATION ALLERGIES**: _____

List **ALL MAJOR SURGERIES** (including eye surgeries):

_____

Female patients: Are you pregnant? _____ Are you nursing? _____

Please indicate if any of the conditions apply to you or a family member (blood relative NOT spouse):

Disease/Condition	Yourself		Family member		Relationship (note maternal or paternal)
	Yes	No	Yes	No	
Cataracts	__	__	__	__	_____
Diabetes	__	__	__	__	_____
Eye Turn (lazy, crossed, etc.)	__	__	__	__	_____
Glaucoma	__	__	__	__	_____
Macular Degeneration	__	__	__	__	_____
Retinal Detachment	__	__	__	__	_____
Blindness			__	__	_____

Review of Systems: Please indicate below if you have or ever had problems with the following conditions:

Immunologic
_ None
_ Shingles
_ HIV positive
_ Sjogren's Syndrome
_ Other_____

Ears,Nose,Mouth & Throat
_ None
_ Sinusitis
_ Hearing Loss
_ Headaches
_ Other _____

Gastrointestinal
_ None
_ Inflammatory Bowel
_ Colitis
_ Acid Reflux/Ulcer
_ Other _____

Skin /Integumentary
_ None
_ Eczema
_ Rosacea
_ Psoriasis
_ Other _____

Psychiatric
_ None
_ Depression
_ Bi-Polar
_ Anxiety
_ Other_____

Cardiovascular
_ None
_ High Blood Pressure
_ Cardiovascular Disease
_ Elevated Cholesterol
_ Stroke
_ Other _____

Endocrine/Glands
_ None
_ Diabetes
_ Hormone Dysfunction
_ Thyroid Dysfunction
_ Other _____

Respiratory
_ None
_ Asthma
_ Bronchitis
_ COPD
_ Other _____

Muscle/Skeletal
_ None
_ Arthritis
_ Fibromyalgia
_ Rheumatoid Arthritis
_ Other _____

Genital/Urinary
_ None
_ UTI Infection
_ Herpes
_ Prostate Disorder
_ Other _____

Hematologic/Lymphatic
_ None
_ Anemia
_ Leukemia
_ Bleeding Disorder
_ Cancer_____
_ Other_____

Neurological
_ None
_ Multiple Sclerosis
_ Epilepsy
_ Tremors
_ Migraines
_ Other _____

Constitutional
_ None
_ Weight loss
_ Weight gain
_ Fatigue
_ Trauma
_ Other _____

Social
__ Current Smoker __ Former Smoker
__ Years Smoking __Years smoke free
__ How many per day __ Never smoked
__ Smokeless Tobacco user

Alcoholic Beverages: _____ per
day week month year (circle one)

Please sign below to acknowledge that this information is correct OR has been reviewed and updateed if necessary:

Signature (Responsible party): _____ Date: _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES
RESPONSIBILITY FOR PAYMENT

Jacobson Eyecare
245 Bloomfield Drive, Suite 108
Lititz, PA 17543

I consent to the use and disclosure of any information concerning my optometric examination as needed to:

- Conduct, plan or direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from insurance or other payers.
- Conduct normal healthcare operations such as recalls and appointment confirmation.

I have read and understand or have been given the opportunity to read your *Notice of Privacy Practices* containing a more complete description of other uses and disclosures of my health information. I understand that your office has the right to change its *Notice of Privacy Practices* from time to time and that I may request a current copy at any time.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

If your office agrees to third party reimbursement for services rendered, I authorize you to submit a vision and/or health benefit claim on my behalf. I understand that I am responsible for all charges incurred, including any portion not paid by any other payer, subject to the conditions of any contractual agreement between your office and such payer.

In addition to my primary care physician, my insurance company and the responsibility party listed on my patient information card, I authorize you to release necessary information to (please list other physicians, family members, opticians, etc.):

_____ _____

_____ _____

_____ _____

PRINT Name of patient **SIGN** Patient or Legal representative

_____ _____

Date Legal representative's relationship

OFFICE USE ONLY:

I attempted to obtain the patient's signature but was unable to do so as documented below:

Date:	Employee Initials:	Reason:

Revised 09/13