PATIENT INFORMATION

PATIENT NAME: ____ BIRTHDATE: ___________ GENDER: __________
LAST FIRST MI

STREET ADDRESS: ____________________________________ CITY: ________________ ST: _______ ZIP: __________

HOME PHONE: _____________ WORK: _________________ CELL: __________________ MAY WE TEXT YOU? Y N

MARITAL STATUS: _______ LAST 4 DIGITS OF 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#:* ______________

NEW PATIENTS *and/or* EXISTING CONTACT LENS PATIENTS

PREVIOUS EYE DOCTOR:_________________________________ LAST EYE EXAMINATION:______________

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

DO YOU HAVE GLASSES WITH YOU TODAY? YES____NO____ ANY VISION ISSUES WITH YOUR GLASSES?______DISTANCE_____NEAR______

DO YOU WEAR CONTACT LENSES? YES NO IF YES: ______ SOFT (BRAND: ____________________) ______ GAS PERMEABLE

HOW MANY YEARS WEARING CONTACTS? _________ HOW OFTEN DO YOU REPLACE YOUR CONTACTS?______________________

MAX # OF HOURS WEARING IN A DAY?_____________HOURS WEARING TODAY?___________IF NOT, LAST TIME YOU WORE:_____________

DO YOU SLEEP IN YOUR CONTACTS? ________HOW OFTEN? 1NIGHT________1 WEEK________2 WEEKS________1 MONTH________

ANY ISSUES WITH YOUR CONTACTS?_____________IF YES ______COMFORT OF LENSES________DISTANCE________NEAR_______________

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 (H) PHONE (C) MAIL EMAIL TEXT

PATIENT HEALTH HISTORY **PATIENT NAME: ______________________________**

FAMILY PRACTICE:________________________LOCATION: ________________________DOCTOR:____________________________
DR's PHONE: __________________ **DATE OF YOUR LAST PHYSICAL/VISIT: ________________**

Medical/Family History (USE BACK OF SHEET TO LIST MEDICATIONS IF MORE SPACE IS NEEDED)

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

____

List **ALL MEDICATION ALLERGIES:** ____

List **ALL NON MEDICATION ALLERGIES**: ____

List **ALL MAJOR SURGERIES AND/OR 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**		**PLEASE INDICATE WHICH FAMILY MEMBER *AND ALSO* INDICATE MATERNAL OR PATERNAL**
	Yes	No	Yes	No	
Eye Turn (lazy, crossed, etc.)	__	__	__	__	______________________________
Glaucoma	__	__	__	__	______________________________
Macular Degeneration	__	__	__	__	______________________________
Retinal Detachment	__	__	__	__	______________________________
Blindness			__	__	______________________________
Diabetes	__*	__	__	__	______________________________

***If yes, How many years have you been diabetic? _________ Type 1 or Type 2 (circle one)**
Circle Treatment INSULIN ORAL MEDICATION DIET CONTROLLED Your last fasting blood sugar #? ______Your last A1C #? _____

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

Immunologic
_ Shingles
_ HIV positive
_ Sjogren's Syndrome
_ Auto-Immune
_ Other ____________

Ears,Nose,Mouth & Throat
_ Sinusitis
_ Hearing Loss
_ Headaches
_ Dry Mouth
_ Other ____________

Gastrointestinal
_ Inflammatory Bowel
_ Colitis
_ Acid Reflux/Ulcer
_ Crohn's Disease
_ Other ____________

Skin /Integumentary
_ Eczema
_ Rosacea
_ Psoriasis
_ Other _______

Psychiatric
_ Depression/Anxiety
_ Bi-Polar
_ ADD/ADHD
_ Autism Spectrum
_ Other _________

Cardiovascular
_ High Blood Pressure
_ Cardiovascular Disease
_ Elevated Cholesterol
_ Stroke
_ Other ____________

Endocrine/Glands
_ Diabetes
_ Hormone Dysfunction
_ Thyroid Dysfunction
_ Other ____________

Respiratory
_ Asthma
_ Bronchitis
_ COPD
_ Other _______

Muscle/Skeletal
_ Arthritis
_ Fibromyalgia
_ Rheumatoid Arthritis
_ Other _______

Genital/Urinary
_ UT Infections
_ Herpes
_ Prostate Disorder
_ Other _______

Hematologic/Lymphatic
_ Anemia
_ Leukemia
_ Bleeding Disorder
_ Cancer______________
_ Other______________

Neurological
_ Multiple Sclerosis
_ Epilepsy
_ Tremors
_ Migraines
_ Other _______

Constitutional
_ 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 confirmations.

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.

Our office may use standard email to communicate with you. Standard email is not secure and does not guarantee privacy.

___ I authorize the use of standard email, in spite of the known risk involved, to communicate with me.

___ I do not authorize the use of standard email to communicate with me.

I acknowledge that I have read and understand or have been given the opportunity to read your Financial Policy and that may request a copy at any time.

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

____ ____

____ ____

________________________ ____

PRINT Name of patient SIGN Patient DATE

If you are signing as a personal representative of the patient, please indicate your relationship. If you are signing for a minor, you attest that you have legal authority to make medical decisions for the minor.

____ ______________________________

Representative Signature Relationship to Patient