PATIENT INFORMATION

PATIENT NAME: _____ BIRTHDATE: _____ GENDER: _____ PERSONAL PRONOUN OR
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 Yes	Yourself No	Family member Yes	Family member No	PLEASE INDICATE WHICH FAMILY MEMBER *AND ALSO* INDICATE MATERNAL OR PATERNAL
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 updated if necessary:

Signature (Responsible party):_____Date: _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES
RESPONSIBILITY FOR PAYMENT and EMAIL CONSENT
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. We will only use standard email for general correspondence, financial statements, contact lens and eyeglass prescriptions. We do not send medical records or insurance explanation of benefits by standard email.
___ 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