PATIENT INFORMATION

Thank you for choosing our practice for your eye care needs. Please complete these forms in clear handwriting so that we may better serve you. If you have any questions or concerns, please do not hesitate to ask for assistance.

Today's date: _____

Name: _____ DOB: _____ Age: _____

FIRST MI LAST

Address: _____ City: _____ State: _____ Zip: _____

Email _____ Cell# _____ Alt/Home#_____

Are you: ☐ Single ☐ Married Gender: ☐ Female ☐ Male ☐ Binary/Other

Primary Doctor Name: _____ Dr's. Phone: _____

You/Parent's employer: _____ Occupation: _____

Whom may we thank for referring you to us? _____

Emergency Contact: _____ Relation: _____ Phone: _____

INSURANCE INFORMATION

Name of insured: _____ Relationship to patient: _____

Birthdate of insurer: _____ Social Security# _____

Insurance Co. Name: _____ ID#_____

Do you have additional insurance? ☐ YES ☐ NO

Insurance Co. Name: _____ ID# _____

MEDICAL HISTORY QUESTIONNAIRE

Does anyone in your immediate family have any of the following conditions? If so, indicate relationship to you for each condition on the lines provided:

☐ BLINDNESS _____ ☐ CATARACT _____ ☐ CROSSED EYES _____

☐ CANCER _____ ☐ GLAUCOMA _____ ☐ DIABETES _____

☐ MACULAR DEGENERATION _____

MEDICAL HISTORY

Are you pregnant and/or nursing? ☐ YES ☐ NO

Do you have any allergies to medication? ☐ YES ☐ NO If yes: _____

List **ALL** medications you are taking: _____

_____

Do you wear contacts? ☐ YES ☐ NO

Do you wear eyeglasses? ☐ YES ☐ NO

Date of last eye exam: _____

Are you interested in wearing contacts? ☐ YES ☐ NO

Do you wear over the counter reading glasses? ☐ YES ☐ NO

Name of eye doctor: _____

SOCIAL HISTORY

Do you drive? ☐ YES ☐ NO

Do you use tobacco products? ☐ YES ☐ NO

Do you use illegal drugs? YES ☐ NO ☐

Do you drink alcohol? YES ☐ NO ☐

Have you ever been exposed to or infected with? If yes, please check the box(s) below.

☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis

Have you ever been diagnosed with any of the following condition? If yes, please check the box(s) below.

☐ Cataracts
☐ Age-related Macular Degeneration
☐ Glaucoma
☐ Diabetes Eye infection, inflammation, or allergy
☐ Diabetic Retinopathy
☐ Retina defects or degenerations
☐ Iritis or Uveitis
☐ Floaters and/or flashes of light
☐ Eye infection, inflammation, or allergy
☐ Dry Eye

Are you having any of the following eye concerns? If yes, please check the box(s) below.

☐ Redness ☐ Discharge ☐ Itching ☐ Eye Strain
☐ Burning ☐ Tearing ☐ Blurred Vision ☐ Sensitivity to Light

Additional eye concerns: _____

Do you currently, or have you ever had any problems in the following areas:

Constitution	**YES**	**NO**
Developmental Disabilities	☐	☐
Cancer	☐	☐
Fatigue Syndrome	☐	☐
Ear/Nose/Mouth/Throat		
Hearing Loss	☐	☐
Sinusitis	☐	☐
Dry Mouth/Throat	☐	☐
Laryngitis	☐	☐
Neurological		
Multiple Sclerosis	☐	☐
Epilepsy	☐	☐
Cerebral Palsy	☐	☐
Tumor	☐	☐
Stroke/CVA	☐	☐
Migraine	☐	☐
Autism Spectrum Disorder	☐	☐
Psychiatric		
Depression	☐	☐
Attention Deficit	☐	☐
Anxiety Disorder	☐	☐
Bipolar Disorder	☐	☐
Cardiovascular		
Stroke/CVA	☐	☐
Heart Disease	☐	☐
Hypertension	☐	☐
Vascular Disease	☐	☐
Congestive Heart Failure	☐	☐

Gastrointestinal	**YES**	**NO**
Crohn's	☐	☐
Colitis	☐	☐
Ulcer	☐	☐
Acid Reflux	☐	☐
Celiac Disease	☐	☐
Genitourinary		
Kidney Disease	☐	☐
Prostate Disease	☐	☐
STD	☐	☐
Benign Prostate Hypertrophy	☐	☐
Musculoskeletal		
Osteoarthritis	☐	☐
Arthritis	☐	☐
Fibromyalgia	☐	☐
Ankylosing Spondylitis	☐	☐
Osteoporosis	☐	☐
Gout	☐	☐
Integumentary		
Eczema	☐	☐
Rosacea	☐	☐
Lupus	☐	☐
Psoriasis	☐	☐
Herpes Simplex/Cold Sores	☐	☐
Herpes Zoster/Shingles	☐	☐

Endocrine	**YES**	**NO**
Type 2 Diabetes	☐	☐
Type 1 Diabetes	☐	☐
Thyroid dysfunction	☐	☐
Hormonal dysfunction	☐	☐
Hematologic/Lymphatic		
Anemia	☐	☐
Large-volume blood loss	☐	☐
Ulcer	☐	☐
Hypercholesteremia	☐	☐
Immune/Allergy		
Rheumatoid Arthritis	☐	☐
Lupus	☐	☐
Sjogren's Syndrome	☐	☐
Drug Allergy	☐	☐
Environmental Allergy	☐	☐
Respiratory		
Asthma	☐	☐
Bronchitis	☐	☐
Emphysema	☐	☐
Chronic Obstruction	☐	☐
Sleep Apnea	☐	☐

PATIENT CONSENT FORM

This form is to inform that New Castle Eye Associates/Middletown Eye Care Notice of Privacy Practice provides information about how we may use and disclose health information about you. The notice contains a Patient Rights section describing your rights under the law. You have the right to review our notice before signing the consent. The terms of our notice may change, if we so, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor the agreement.

By signing the form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

1. Protected health information may be disclosed or used for treatment, payment or health care operations, including appointment reminders by post card or messages on an answering machine.
2. The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
3. The Practice reserves the right to change the Notice of Privacy Policies.
4. The Patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
5. The patient may revoke this consent in writing at any time and all future disclosures will cease.
6. The Practice may condition treatment upon the execution of this consent.

This Consent allows the practice to disclose my information to the following people:

Spouse: _____ Parent: _____

Children: _____ Other: _____

Signature of Consent: _____ Date: _____

Relationship to Patient: _____ Date: _____

In front of _____
(Practice Representative)

SIGNATURE ON FILE

- I authorize use of this form on all my insurance submissions.
- I authorize release of information to all my insurance companies.
- I understand that I am responsible for my bill id the insurance company does not pay for any reason.
- I authorize my doctor to act as my agent in helping me obtain payment for my insurance companies.
- I authorize payment direct to my doctor.
- I permit a copy of this authorization to be used in place of the original.
- I agree to pay all fees plus prevailing interest if I am taken to collections for unpaid bills.

Printed Name **Signature** **Date**

ANNUAL WELLNESS RETINAL IMAGING

As part of your eye exam, our optometrists recommend a special diagnostic procedure called Fundus Photography Imaging. This procedure consists of capturing an image of the back part (retina) of your eye. This is not an x-ray or ultrasound procedure; and nothing will touch your eye.

This permanent record is very valuable in assessing the current health of your eye and for safeguarding the health of specific structures of your eye, such as the retina, optic nerve, macula, and blood vessels. It will also serve as an initial point from which to compare, as we follow your health in subsequent years.

The fee for Fundus Photography Imaging is $39.00. Fundus images are also not covered under most vision plans.

_____ Yes, I want to have retinal photos taken of my eye for documentation.

_____ No, I do not wish to have retinal photos taken.

Patient Signature: _____ Date: _____

PATIENT PORTAL ENROLLMENT

We are pleased to announce the development and roll out of "Going Green" - our new electronic and environmentally friendly programs, effective October 2018. Along with going green we now offer a patient portal that gives you convenient access to your prescriptions, real-time access to medical records, secure patient-provider communication, and more. We encourage you to complete your registration and utilize the patient portal to take advantage of all the new great features.

If you would like to register for the patient portal, please provide your email address below and we will setup your account for you.

Once your setup you can register by going to **https://revolutionphr.com/** and input your login and temporary password.

Patient Email Address: _____

Temporary Password: ___WELCOME1_____

“NO SHOW” AND “CANCELLATION” POLICY & PROCEDURE

At New Castle Eye Associates/Middletown Eye Care our goal is to provide quality ophthalmic care in a timely manner. We have implemented a no show and cancellation policy which enables us to better utilize available appointments for our patients in need of care. Available appointments are in high demand and your early cancellation will give another person the possibility to have access to timely ophthalmic care.

- Patients who fail to show for their scheduled appointment or did not notify the office within 48 hours of their scheduled appointment time, shall be subject to a “No Show/Cancellation” fee of $25.00.
- These fees are not covered by insurance and are therefore the sole responsibility of the patient.
- This “no-show charge” is due at time of rescheduling your appointment.

As a courtesy, and to help patients remember their scheduled appointments, we send text message and email reminders 7 days, 2 days, and 2 hours in advance of the appointment time. If your schedule changes and you cannot keep your appointment, please contact us so we may reschedule you, and accommodate those patients who are waiting for an appointment.

How to Cancel Your Appointment

To cancel or reschedule appointments please call the office directly. If you have any problems getting through, you can leave a message with your name, date of birth, appointment date and cancellation reason or request for rescheduling.

_____ _____

Patient Signature Date