INFOCUS
FAMILY EYECARE

PATIENT REGISTRATION & MEDICAL HISTORY FORM

Legal Name: ______________________ Preferred Name: ______________

Birth Date: ____ /____ /______ Social Security Number: ______ - ____ - ________ Guardian(s) : ______________ Sex: **M / F**

Home Address: ______________________ City: ____________ State: ____ Zip: ________

Which phone number would you prefer we use to contact you? ☐ **Home** ☐ **Cell** ☐ **Other** Home Phone: ______________

Cell Phone: ____________ Other: ____________ E-mail address: ______________

Marital Status: ☐ **Single** ☐ **Married** ☐ **Other** Referred by: ____________ ***We must have a copy of all insurance cards on the day of service**

Primary Medical Insurance: ______________ **Secondary Medical** Insurance: ______________

Vision Insurance: ______________ Insured Social Security Number: ______________

Insured's Birth Date: ______________ Insured's Employer: ______________

Family Doctor: ______________ Family Dr. Clinic/Phone: ______________

Family Members: ______________________ For ease of data transfer, are they patients at this office? **Y / N**

CHIEF COMPLAINT

How can we help you today? In this space please check/explain any signs and/or symptoms that you experience.

☐ **Loss of vision**	☐ **Floaters**	☐ **Eye pain/soreness**	☐ **Glare**	☐ **Dry eyes**
☐ **Blurred vision**	☐ **Crossed eyes**	☐ **Watery eyes**	☐ **Light sensitivity**	☐ **Red eyes**
☐ **Double vision**	☐ **Flashes of light**	☐ **Sandy/gritty feeling**	☐ **Tired eyes**	☐ **Burning/itching**

Other (explain): ______________________

HISTORY OF PRESENT ILLNESS

1. *Which eye has the problem?* ☐ **Right** ☐ **Left** ☐ **Both**
2. *Is it new, ongoing, returning?* ☐ **New** ☐ **Ongoing** ☐ **Returning**
3. *How is it affecting you?* ☐ **Bothersome** ☐ **Aware** ☐ **Painful**
4. *Associated w/:* ☐ **Infection** ☐ **Medical condition** ☐ **Injury** ☐ **Surgery**
5. *How severe is the problem?* ☐ **Mild** ☐ **Moderate** ☐ **Severe**
6. *Previous treatment?* ☐ **Drops** ☐ **Medication** ☐ **Other** ____________

Duration
How long have you had the problem? ____________
Symptoms
Are there associated symptoms? ☐ **Headache** ☐ **Other:** ______

FAMILY HISTORY

Has anyone in your family (parents, grandparents, siblings, children, living or deceased) been diagnosed with any of the following (check all that apply):

	Relationship to you:		Relationship to you:
☐ **Diabetes**	____________	☐ **Cataracts**	____________
☐ **High blood pressure**	____________	☐ **Macular degeneration**	____________
☐ **Cancer**	____________	☐ **Strabismus (eye turn)**	____________
☐ **Amblyopia**	____________	☐ **Glaucoma**	____________
☐ **No significant family history**		☐ **Other**	____________

SOCIAL HISTORY

Do you smoke? ☐ **Y** ☐ **N**
If yes, what do you smoke? ☐ **Cigarettes** ☐ **Cigars** ☐ **Pipes**
How much per month do you smoke? ____________

Do you consume alcohol? ☐ **Y** ☐ **N**
If yes, how much do you drink? ____________

What is your occupation? ______________________

TURN OVER AND CONTINUE ON OTHER SIDE

CURRENT VISION

Glasses: Do you currently wear glasses? ☐ **Y** ☐ **N** *if yes, answer the questions below; if no, continue to contact lenses section:*
What type of lenses are in your glasses? ☐ **Single vision** ☐ **Bifocal** ☐ **Trifocal** ☐ **No-line (Progressive)**

Contact Lenses: Do you currently wear contact lenses? ☐ **Y** ☐ **N** *if yes, answer the questions below; if no, continue to past ocular history section:*
What type of contact lenses do you wear? ☐ **Soft** ☐ **Rigid**
What is the manufacturer/model of your contact lenses? ________________________________
What are the powers of your contact lenses (if you know)? ________________________________
How old are your current contact lenses? ______ **Months / Years**
How often do you replace your contact lenses? ☐ **Daily** ☐ **Weekly** ☐ **2 weeks** ☐ **Monthly** ☐ **3 months** ☐ **6 months** ☐ **Annually**
What solutions do you use to care for contact lenses? ☐ **Biotrue** ☐ **Optifree** ☐ **Clear Care** ☐ **RevitaLens** ☐ **Other** ____________________

REVIEW OF SYSTEMS

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

Ocular/Eye Problems		**If yes, please explain**
Loss of Vision	☐ **Y** ☐ **N**	________________
Blurred Vision	☐ **Y** ☐ **N**	________________
Distorted Vision / Halos	☐ **Y** ☐ **N**	________________
Loss of Side Vision	☐ **Y** ☐ **N**	________________
Double Vision	☐ **Y** ☐ **N**	________________
Dryness	☐ **Y** ☐ **N**	________________
Mucous Discharge	☐ **Y** ☐ **N**	________________
Redness	☐ **Y** ☐ **N**	________________
Sandy or Gritty Feeling	☐ **Y** ☐ **N**	________________
Itching	☐ **Y** ☐ **N**	________________
Burning	☐ **Y** ☐ **N**	________________
Foreign Body Sensation	☐ **Y** ☐ **N**	________________
Excess Tearing / Watering	☐ **Y** ☐ **N**	________________
Glare / Light Sensitivity	☐ **Y** ☐ **N**	________________
Eye Pain or Soreness	☐ **Y** ☐ **N**	________________
Chronic Infection of Eye or Lid	☐ **Y** ☐ **N**	________________
Sties or Chalazion	☐ **Y** ☐ **N**	________________
Flashes / Floaters in Vision	☐ **Y** ☐ **N**	________________
Tired Eyes	☐ **Y** ☐ **N**	________________

CARDIOVASCULAR (heart/blood vessels)	☐ **Y** ☐ **N**	________________
RESPIRATORY (lungs/breathing)	☐ **Y** ☐ **N**	________________
GASTROINTESTINAL (stomach/intestines)	☐ **Y** ☐ **N**	________________
GENITOURINARY (genitals/kidney/bladder?	☐ **Y** ☐ **N**	________________
MUSCULOSKELETAL (muscles/joints)	☐ **Y** ☐ **N**	________________
INTEGUMENT (skin/breasts)	☐ **Y** ☐ **N**	________________
PSYCHIATRIC (anxiety/depression)	☐ **Y** ☐ **N**	________________
NEUROLOGICAL	☐ **Y** ☐ **N**	________________
ENDOCRINE (hormones/glands)	☐ **Y** ☐ **N**	________________
HEMATOLOGIC/IMMUNOLOGIC (blood)	☐ **Y** ☐ **N**	________________
ALLERGIES (all allergies, seasonal or not)	☐ **Y** ☐ **N**	________________

List all ALLERGIES to medications: ________________________________
List all medications you are currently taking: ________________________________
____

Signature: ________________________________ **Date:** ____________________

HIPAA Privacy Acknowledgement of Receipt of Notice of Privacy Practices

I, ________________________________ (the patient or patient's legal representative), have been presented with the Notice of Privacy Practices (the "Policy") of InFocus Family Eyecare (the "Provider"), and have been offered a copy of such policy to keep for my records.

X____

(Signature) (Date)

Authorization for the Use and Disclosure of Individually Identifiable Health Information

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand the information I authorize a person or entity may be re-disclosed and no longer protected by federal privacy regulations.

1. Persons/organizations authorized to use or disclose the information: Office of InFocus Family Eyecare
2. Specific description of information that may be used/disclosed: My name, address, telephone number, email address, and next appointment date(s) & time(s).
3. As part of our recall program, the information might be used/disclosed for the following purposes:
   a. For the purpose of providing coupons and service and product information from InFocus Family Eyecare; and
   b. To contact you regarding scheduling eye exams via text, phone, and/or email.
4. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, receive payment or eligibility for benefits unless allowed by law.
5. The organization authorized to use/disclose the information will NOT receive compensation for doing so.
6. I understand that I may inspect or copy the information used or disclosed.
   a. I understand that I may revoke this authorization at any time by notifying the person/organization providing the information in writing, except to the extent that action has been taken in reliance on this authorization.
7. This authorization expires four (4) years from the date of my signature.

X____

(Signature) (Date)

InFocus Family Eyecare – Patient/Guardian Authorization

Release of Information/Assignment of Benefits

I hereby authorize InFocus Family Eyecare to release any medical or incidental information that may be necessary for medical benefit of in processing applications for financial benefit. This includes but is not limited to my insurance company, Rehabilitation Services, Social Security Administration, and Worker's Compensation. I permit a copy of this to be used in place of the original. I authorize the provider to act as my agent in helping me obtain payment from my insurance companies. I hereby authorize InFocus Family Eyecare to apply for benefits on my behalf for covered services rendered by them, I also assign my benefits and request that all payments from the insurance company be made directly to InFocus Family Eyecare. I understand that I am responsible for payment of all charges. As a courtesy, my insurance will be billed for me. It is my responsibility to pay any deductible, copay or any other balance not paid by my insurance company.

If applicable, I agree to receive my finalized contact lens prescription via the patient portal.

VISION PLAN COVERAGE: I/We understand that only one vision plan may be used for exam/materials per visit-per patient and that the vision plan to be used must be chosen before the exam occurs and cannot change at a later date.

Due to changes in insurance regulations, if you have both a vision plan and a medical insurance plan, we are now required to coordinate your benefits with both plans. If you are being seen for a medical problem, or if you have any medical conditions that can affect the eyes or vision, your medical insurance will be billed first. Some of these medical conditions include: macular degeneration, diabetes, high blood pressure, blurred vision, glaucoma, flashes, floaters, rosacea, eye pain, itchy eyes, Bell's Palsy, double vision, allergies, foreign body, eye trauma, corneal ulcers, eye injury, swollen eyelids, headaches, chalazion, dry eye, red eyes, stye, drooping eyelids, "pink eye", burning eyes, shingles, etc. If you are here for a comprehensive, or annual exam, we must now submit the eyeglass prescription determination portion of the visit to your vision plan after submitting any medical claim to your medical insurance plan. You may still use vision plan materials benefits, if eligible, at the time of your exam.

Consent to Treat

I voluntary consent to such care and treatment as prescribed by the doctor as is necessary in his/her judgement.

I certify that the information I have reported with regards to my coverage is correct. This authorization is in effect until revoked in writing by the patient.

X____

(Signature) (Date)