PATIENT INFORMATION REQUEST FORM

Welcome to our office! *Our goal is to provide you with the best, personalized vision care possible. To accomplish this goal, we need to know everything about your eyes, your visual needs, and your present health. Please answer the following questions completely so we may tailor our examination to fit your needs.* We will not share or sell your e-mail address, street address, or phone number.

PATIENT NAME _____ Occupation _____ Employer _____
What salutation do you prefer (circle): Mr. Mrs. Ms. Miss. Dr.

How do you prefer to be addressed? _____ E-mail address _____
May we communicate with you by e-mail? No Yes Yes, including your special promotions.
Whom may we thank for referring you to our office?
_____ Family member _____
_____ Coworker or friend _____
_____ Doctor _____
_____ not a personal referral, but live nearby
_____ not a personal referral, but work nearby
_____ Internet search
_____ Insurance list
_____ Newspaper Ad
_____ selected your office because _____

Year of last eye exam _____ at (Clinic or Doctor)_____
How many hours a day do you read or do desk work, including computer work? _____
How far away from your eyes is the computer screen? ___inches. Where is the screen? ___At ___Above ___Below eye level
In which of the following activities do you often participate? (circle as needed)
fishing boating swimming/water sports snow sports biking crafts tennis/racquet/handball running golfing gardening reading painting acting/dancing motorcycling playing a musical instrument computer/video games
Other:_____
Are you wearing contact lenses today? Yes No Do you sometimes wear contacts? Yes No

List your general medical doctor, his/her clinic and phone number

Dr._____ **at** _____ **phone** _____

Please check if you have or have had:
_____ glaucoma
_____ cataract _____ cataract surgery, year(s) _____
_____ retinal problem
_____ eye surgery, including LASIK, PRK or RK
_____ lazy, crossed or wandering eye
_____ serious eye injury, date _____
_____ serious eye infection, date ____
_____ other eye diseases, please list _____
_____ **I do not have any of the above or other eye conditions.**

Has anyone in your family has had these or other eye conditions? Please list which family member.
_____Glaucoma: (who? _____)
_____Crossed, wandering or lazy eye: (who?)_____
____Blindness, even in later life: (who?) _____
____Other, list what and family member_____

Tell us about your health. Do you have any of the conditions listed below? List any current medications (prescribed or over the counter) or treatments, even if unrelated to the eyes.

	NO	**YES**	**List Medication or Treatment**
Cancer, type _____	___	___	_____
ENT: Sinus, throat, hearing loss, etc	___	___	_____
Neuro: Epilepsy, Stroke, Migraine	___	___	_____
Psychiatric: Anxiety, Depression, etc	___	___	_____
Cardiovascular: High Blood Pressure	___	___	_____
High cholesterol, Heart condition	___	___	_____
Respiratory: Asthma, sleep apnea, etc	___	___	_____
Gastrointestinal: Ulcer, Crohns, Celiac	___	___	_____
Musculoskeletal: Arthritis, Fibromyalgia	___	___	_____
Skin: Eczema, Rosacea, Herpes, etc	___	___	_____
Endocrine: Diabetes, Thyroid	___	___	_____
Birth control, hormones	___	___	_____
Immune: Lupus, seasonal allergies, etc	___	___	_____
Other _____	___	___	_____

Are you: (please circle)
Pregnant/ breastfeeding? No Yes
Allergic to Latex? No Yes
Allergic to medications? No Yes
If Yes, list medications below:

_____ **I do not have any of the above, or other health conditions, or take any medication.**

SIDE 2.
PATIENT NAME _____

Meaningful Use

Meaningful Use is a US government initiative designed to ensure the highest quality of healthcare through the use of electronic health records. Healthcare providers are strongly encouraged to participate in this program. Please help us comply with the government regulations by answering the following questions (all terms are specified by the US government's Meaningful Use Program).

Preferred language: _____

Race (please circle): White/Caucasian Black/African American Indian: Continent of India Asian American Indian/Alaska Native
Native Hawaiian or other Pacific Islander Other race: _____

Ethnicity (please circle): Hispanic or Latino Not Hispanic or Latino

Do you drink alcohol? (please circle): No Yes: If yes, how many drinks per week? _____

Do you smoke? (please circle): Never Not now Yes: If yes, how do you smoke and how often? _____

*******PLEASE SIGN **ALL THREE** POLICY NOTIFICATIONS *******

1) Payment Policy: Payment is required when services are rendered or materials are ordered. Quotes of insurance coverage are based on information from the insurance company and are not guaranteed. Although we will gladly bill insurance for you, patients remain responsible for their charges even after insurance has been billed. If payment has not been received from insurance after 60 days, the patient will be expected to pay Hawthorne Vision Center directly.

"I understand that I am personally responsible for payment of my account even if I have insurance. If it becomes necessary to use a collection agency for any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses including reasonable attorney's fees. Accounts assigned to collections will be charged a minimum of a $ 50 collections fee."

Signed _____ **Date** _____

2) Privacy Policy: This allows us to bill your insurance and make medically necessary referrals.
"I hereby authorize release of information to my insurance company or to any health care professional when necessary for my health care or billing."

Signed _____ **Date** _____

3) HIPPA Policy: Due to new HIPAA Privacy Regulations, our office is required to offer you a notice of our privacy practices. This document lets you know what steps we take to protect your personal health information. A copy is attached to this form. Please ask the receptionist if you would like an additional copy of this document. ____ don't want a copy ____ received copy

Signed _____ **Date** _____

Thank you for your help. Now we know just what type of care and service to provide.
Please let us know if you have any special needs not addressed by this form.