NEW PATIENT REGISTRATION INFORMATION

PATIENT INFORMATION: (*PLEASE PRINT OR CIRCLE THE APPROPRIATE INFORMATION BELOW)*

Last Name: _____ First: _____ MI: _____

Address: _____ Apt/Unit/Lot#: _____

City: _____ State: _____ Zip Code: _____ Gender: Male / Female

Date of Birth: _____ SS#: _____ Marital Status: Married/Single/Widowed/Divorced

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Race: _____ Ethnicity: _____ **IS TEXTING OK? YES NO**

Spouse: _____ Spouse DOB: _____ Spouse SSN: _____

Email address: _____

Patient Employment Status: Full Time/ Part Time/ Retired/ Disabled/ Student/ Not Employed/ Other

Patient Employer: _____ Occupation: _____

Primary Care Doctor: _____ PCP Office Phone #: (____) _____

INSURANCE INFORMATION: FOR BILLING PURPOSES, ALL INSURANCE CARDS AND A PICTURE ID *WILL* BE SCANNED *(PLEASE COMPLETE IN FULL)*

1. Primary **Vision** Insurance: _____ ID#: _____

2. Primary **Medical** Insurance: _____ ID#: _____

Guarantor Name: _____ Gt. DOB: _____ Gt. SS#: _____

Guarantor Address: _____ City,State,Zip: _____

Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____

3. Secondary **Medical** Insurance: _____ ID#: _____

RESPONSIBLE PARTY: *(NEEDED ONLY IF PATIENT IS A MINOR OR OTHER DEPENDENT)*

Name: _____ Resp. Party Date of Birth: _____

Address: (if different than patient): _____

Street Address City State Zip

Primary Phone: _____ Secondary Phone: _____

Resp. Party: SSN: _____ Resp. Party Employer: _____

REASON FOR EXAMINATION: _____ Routine Exam _____ Contact Lens Exam _____ Medical Problem

DATE OF LAST EYE EXAMINATION: _____ DO YOU CURRENTLY WEAR CONTACT LENSES? Y / N

MEDICAL HISTORY QUESTIONNAIRE

PREVIOUS OPTICAL HISTORY:

PRESCRIPTION GLASSES: Do You Wear Prescription Glasses? YES / NO How many hours per day? ____

How long have you been wearing prescription glasses? _____ Do you have problems with glare? YES/NO

Do you have problems with driving at night or night vision in general? YES/NO_____

Computer Use: Do you often use computers? YES / NO How many days per week? ____ per day? ____

Do you get headaches or eye strain after viewing a screen? YES / NO Other: _____

CONTACT LENS: Do You Wear Contact Lenses? YES / NO DATE PRESCRIBED: _____

How long have you been wearing contact lenses? _____ Type of Lens: _____

REVIEW OF SYSTEMS

Have you ever had any problems in the areas listed below? If so, please check and circle all areas that apply.

	NO	YES	?
CONSTITUTIONAL			
Fever, Weight gain/loss	□	□	□
INTEGUMENTARY (SKIN)	□	□	□
NEUROLOGICAL			
Headaches, Migraines, Seizures	□	□	□
EYES			
Loss of vision	□	□	□
Blurry vision	□	□	□
Distorted vision	□	□	□
Haze	□	□	□
Halos	□	□	□
Starbursts	□	□	□
Glare/Light Sensitivity	□	□	□
Double vision	□	□	□
Sandy/Gritty/Dry Feeling	□	□	□
Burning	□	□	□
Itching	□	□	□
Tearing/Watering	□	□	□
Pain/Soreness	□	□	□
Infection of eyelids	□	□	□
Tired eyes	□	□	□
Flashes/Floaters	□	□	□
ENDOCRINE			
Thyroid/Other glands	□	□	□
Diabetic	□	□	□

	NO	YES	?
EARS, NOSE, MOUTH, THROAT			
Allergies/ Hay fever/runny nose	□	□	□
Sinus congestion	□	□	□
Dry throat/mouth	□	□	□
Chronic cough	□	□	□
RESPIRATORY			
Chronic Bronchitis	□	□	□
Asthma, Emphysema	□	□	□
IMMUNOLOGIC: _____	□	□	□
CANCER: _____	□	□	□
VASCULAR/CARDIOVASCULAR			
Vascular disease, Heart disease	□	□	□
High Blood Pressure	□	□	□
GASTROINTESTINAL			
Constipation, Diarrhea	□	□	□
GENITOURINARY			
Kidney/Bladder	□	□	□
SKELETAL/JOINTS/MUSCLAR	□	□	□
Joint Pain, Arthritis, Lupus	□	□	□
Connective Tissue Disease	□	□	□
PSYCHIATRIC	□	□	□
LYMPHATIC / HEMATOLOGIC			
Anemia	□	□	□
Bleeding Problem	□	□	□
PREGNANT?	□	□	□

FAMILY HISTORY: Has any member of your family had any of the following:
(Please circle all that apply)DIABETES**,** RETINAL DETACHMENT/DISEASE**,** GLAUCOMA**,** MACULAR DEGENERATION**,** CATARACTS**,** CROSSED EYES**,** LAZY EYE, BLINDNESS, DEATH DUE TO ANETHESIA **(If so, please list relationship below):**_____

ALLERGIES: **ARE YOU ALLERGIC TO ANY MEDICATIONS? YES / NO If yes, please list the medication:**_____

MEDICATIONS: **ARE YOU CURRENTLY TAKING ANY MEDICATIONS? YES / NO If yes, please list them:**
Name of Medication Strength Dose Frequency

_____

_____

_____

PLEASE LIST MAJOR ILLNESSES: _____

_____

PLEASE LIST MAJOR SURGERIES: _____

_____

SOCIAL HISTORY: Do you use tobacco products? Y / N (If YES, what type/ how much) _____

Do you use alcohol products? Y / N (If YES, what type/ how much) _____

Do you use illegal drugs? Y / N (If YES, what type, how much) _____

Have you been exposed to, or do you have, or ever have had: HEPATITIS B/HIV/AIDS/OTHER: _____

The Health Insurance Portability and Accountability Act (HIPAA) provide safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003 and revised on September 26, 2013. Many of the policies have been our practice for years. This form is a summary version explaining what HIPAA is and how it protects you.

These are rules and restrictions on who may see or be notified of your Protected Health Information, (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services, (www.hhs.gov). We have adopted and implemented the following policies:

1. Patient information will be kept confidential except as necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be left, at least temporarily, in administrative areas such as the front office, examination room, etc., however records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI, and other documents or information. Also, PHI is stored electronically on our secured electronic health record software/database. It is available electronically to our patients upon written request in accordance with state and federal laws.
2. It is the policy of this office to remind patients of their appointments. This includes but is not limited to telephone, email, U.S. Mail, or by any means convenient for the practice and/or as requested by you with regard to revealing as little PHI as possible.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI and must sign agreements to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. Your confidential information will not be used for the purposes of marketing or advertising of products, goods, or services. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
6. We may change, add, delete, or modify any of these provisions to better serve the needs of both the practice and the patient. You agree to bring any concerns or complaints regarding privacy to the attention of Dr. Stephen Enochs.
7. You have the right to request restrictions in the use of your PHI with a written request and to request change in certain policies used within the office concerning your PHI. However, we reserve the right to deny the request if necessary, and are not obligated to alter internal policies to conform to your request.

HIPAA PATIENT RIGHTS AND ACKNOWLEDGEMENT

I, _____, on this date, _____, do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA PATIENT RIGHTS AND ACKNOWLEDGMENT FORM (see reverse), and any subsequent changes in office policy. I understand that this consent shall remain in force located in my record from this time forward.

I give *consent* for the following to have access to my medical record (i.e. family, legal guardian, etc.) _____.

FINANCIAL POLICY: Thank you for choosing Enochs Eye Care PLLC as your eye health care provider. Our office will file insurance claims as a courtesy to our patients, including Medicare, Virginia Medicaid, Anthem, Optima, CIGNA, UnitedHealth Care, and any other commercial plans that we participate with. Please remember that your insurance is a contract between you and your insurance company and any and all copays and deductibles are due at the time of treatment. All necessary referrals are ultimately the responsibility of the patient, as per your insurance guidelines**. It is the responsibility of the patient to update Enochs Eye Care PLLC of any and all demographic and insurance changes at the time of service as well as current insurance cards. Failure to do so will result in the patient being responsible for 100% of the services and products charged.**

I agree that in return for the services provided to the patient by Enochs Eye Care PLLC, I will pay my account at the time services are rendered or will make financial arrangements satisfactory to Enochs Eye Care for payment. If an account is sent to a collection agency and/or attorney for collection, I agree to pay the collection expenses of 33.3% in addition to the amount due and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand that there is a $35 fee for all returned checks. I understand that if my account is delinquent, I may be charged interest at the legal rate. I hereby authorize my insurance company to reimburse Enochs Eye Care PLLC directly. If copayments and or deductibles are designated by my insurance company or health plan, I agree to pay them to Enochs Eye Care PLLC. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

Patient Signature: _____ Date: _____

Responsible Party: _____ Date: _____

Vision services is a broad term that means care of the eyes. Vision services are usually either "routine" or "medical". Although the exams and activities may be similar, the reason for the visit and/or condition(s) revealed during the visit, determine whether it is a routine or medical visit. Benefits vary depending on these aspects. Most vision insurances cover 1 routine eye exam per year. They generally do not cover the treatment and management of medical eye conditions (as explained below).

• Routine eye exam (covered by vision insurance): A routine eye exam generally covers an eye wellness examination including a refraction to test whether corrective lenses are necessary. After a routine exam, a prescription for corrective lenses (glasses/contact lens) may be given to the patient.

• Medical eye exam (covered by medical insurance): Medical eye exams are often done if you have an eye problem, eye disease, or if any medical condition is present that may impact eye health. Some common conditions for which medical eye exams are conducted include allergies, dry eye, infections, eye trauma, glaucoma, diabetic retinopathy, macular degeneration, and cataracts. This also includes patients using medications with potential eye side effects, as well as patients with chronic medical conditions that may impact their eye health.

If medical eye conditions are being diagnosed, treated, or managed and/or if prescriptions are written or refilled, this elevates the level of complexity. In these cases, your medical insurance will be billed and insurance co-pays, cost shares, and deductibles may apply, depending on your insurance plan. We encourage you to contact your insurance carrier(s) if desired to obtain more detailed information about your coverage and benefits.

Your signature below indicates that you have read and acknowledge the above statement.

_____ _____

Patient's Signature (or representative) **Date**

_____ _____

Printed name of patient **Printed name of representative (if applicable)**