Johnson Eye Care Patient Information

Last Name: _____ First Name: _____ MI: _____

Gender: ☐Male ☐Female Date of Birth: ____/____/____ Social Security# _____-_____-_____

Primary Care Dr: _____ Marital Status ☐Single ☐Married ☐Widowed ☐Divorced ☐Domestic Partner

Patient Address: _____ City: _____ State: _____ Zip Code: _____

Telephone Numbers Cell: _____ Home: _____

Employer's Name: _____ Occupation: _____ Phone: _____

Race: ☐Asian ☐Native Hawaiian ☐Other Pacific Islander ☐Black/African American
☐American Indian/Alaskan Native ☐White ☐More than one Race ☐Decline to answer

Ethnicity ☐Not Hispanic/Latino ☐Hispanic/Latino ☐Decline to answer

Language ☐English ☐Spanish ☐Other: _____ E-Mail: _____

Insurance

Insurance card(s) or proof of insurance must be presented at the time of service

Primary Insurance: _____

If you are not the policy holder, please complete the following information

Policy Holder's Name: _____ Date of Birth: _____ Policy Number: _____

Secondary Insurance:

If you are not the policy holder, please complete the following information

Policy Holder's Name: _____ Date of Birth: _____ Policy Number: _____

Assignment and Authorization of Benefits for Patients WITH Insurance

I hereby state that the above information is true and correct to the best of my knowledge. I hereby assign, transfer, and set over to Johnson Eye Care all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization will remain valid until I revoke it by written notice. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

_____ _____

Signature of Patient or Personal Representative Date

*****Financial acknowledgement for Private Pay Patients or Patients WITHOUT Insurance*****

Patients who do not have insurance coverage are expected to pay charges in full at the time services are rendered. I agree that I am financially responsible for all charges incurred during the time of service.

_____ _____

Signature of Patient or Personal Representative Date

Johnson Eye Care Past Medical/Surgical History

New Patient Information

Please take the time to complete the following form so that we may better understand your medical history. This information will be treated with strict confidentiality.

Please indicate if you have ever been treated or hospitalized for any of the following conditions and provide the date if known.

Condition	Condition	Condition	Condition
☐ Abnormal Heart rhythm	☐ Hemorrhoids	☐ Kidney failure/dialysis	☐ Tuberculosis
☐ High Cholesterol	☐ Cirrhosis	☐ Osteoporosis	☐ Psoriasis
☐ High Blood Pressure	☐ Gallstones	☐ Osteopenia	☐ Eczema
☐ Heart Attack/CAD	☐ Stroke/TIA	☐ Osteoarthritis	☐ Shingles
☐ Congestive Heart Failure	☐ Seizures/Epilepsy	☐ Back pain	☐ Crohn's
☐ Murmur	☐ Headaches/Migraines	☐ Anemia	☐ Celiac Disease
☐ Peripheral Vascular Disease	☐ Neuropathy	☐ Lupus	☐
☐ COPD/Emphysema	☐ Depression	☐ Rheumatoid Arthritis	☐ Fibromyalgia
☐ Asthma	☐ Anxiety	☐ Diabetes Type 1 or 2	☐ Gout
☐ Blood Clot to lungs	☐ Cataracts	☐ Thyroid Problems	☐ Insomnia
☐ Reflux/GERD	☐ Glaucoma	☐ Seasonal Allergies	☐ Cancer (Please List)
☐ Hormonal Dysfunction	☐ Retinopathy	☐ HIV/AIDS	
☐ Sjogren's Syndrome	☐ Recurrent UTI	☐ Hepatitis B or C	☐ Other (Please List)
☐ Irritable Bowel Syndrome	☐ Kidney Stones	☐ Sexually transmitted diseases	

Please List all past surgeries or Injuries and dates if known.

Surgery /Injury	Date	Surgery/Injury	Date

Please list any Other Physicians You see

Physician	**Specialty**

List RX Medications

Current Medications	**Conditions**

OCULAR HISTORY

Eye Conditions:

Have you ever been diagnosed with the following conditions? Please circle answers:

☐**Cataracts** Surgery**:** Yes or No **If YES,** Right or Left or Both **Dates: _____**

☐**Glaucoma** Surgery**:** Yes or No **If YES, which drops do you use? _____**

☐**Diabetic Retinopathy** Surgery**:** Yes or No **If YES,** Right or Left or Both eye(s)

☐**Macular Degeneration** Treatment: Yes or No **If YES,** Right, Left or Both eye(s)

☐**Floaters and/or Flashes of Light:** Yes or No **If YES,** Right, Left or Both eye(s)

☐**Dry Eyes:** Drops Used: Yes or No **If YES, name of drops? _____**

☐**Eye Infection, Inflammation or Allergy**: Drops Used: Yes or No

☐**Have you had corrective eye surgery? LASIK RK PRK Refractive Lensectomy**

Other: _____

Eye Concerns:

☐**Redness**

☐**Burning**

☐**Itching**

☐**Watering**

☐**Discharge**

☐**Double Vision**

Vision Concerns:

☐**Vision Blurred/Eye Strain**

☐**Eye Pain**

☐**Headaches**

☐**Sensitivity to lights**

Do you currently wear: Glasses Contact Lenses Both Nothing

How many hours do you spend on a computer or electronic device (phone, tablet, etc.) per day?

_____

Johnson Eye Care HIPAA Acknowledgement

Patient Name: _____ Date of Birth: _____

Notice of Privacy Practices

_____ **(Patient Initials)** I acknowledge that I have received the Johnson Eye Care Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations, and other described and permitted uses and disclosures. I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information and for the purposes described in the practice's Notice of Privacy Practices.

Release of Information

_____ **(Patient Initials)** I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: * Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly. * Obtain payment from designated third-party payers. * Conduct normal health care operations such as quality assessments or evaluations and physician certifications. I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand the organization is not required to agree to my requested restrictions.

Disclosures to Friends and/or Family Members

I give permission for my Protected Health Information to be disclosed by phone, email, fax or in person for purposes of picking up prescriptions, communicating results, findings, and care decisions to the family members and others listed below:

Name	Relationship	Contact Number

****This release will remain in effect until it is revoked in writing by the patient****

_____ _____

Signature of Patient or Personal Representative **Date**