

CONFIDENTIAL PATIENT INFORMATION

PATIENT INFORMATION

Full Name _____ Phone # (Home) _____ (Day) _____
Nickname _____ (Cell #) _____ Language _____
Date of Birth _____ Race _____ Ethnicity _____
Last 4 of SSN _____ E-mail address _____
Address _____ M/F _____ Marital status _____
City _____ State _____ Zip _____ Reminders by mail, phone, text, or e-mail. _____

INSURANCE AND FINANCIAL INFORMATION

Medical insurance carrier(s) _____ Employer _____
Vision insurance _____ Other insurance _____
Name of insured person (if not patient) _____
Birthdate of insured _____ Last 4 of SSN of insured _____
Person responsible for account (if not patient) _____

REQUEST AND RELEASE OF INFORMATION

I understand that Drs. Stoppel & Brown (this Practice) will contact my Medicare/Medicaid/Other insurance carrier regarding coverage of services provided to me. I authorize my physician and other medical entities to release my confidential medical information to this Practice concerning my medical history. I authorize this Practice to release my confidential medical information to my health insurance carrier to facilitate reimbursement for my medical fees, to my physician and to other medical entities for coordination of care. _____ initial

AUTHORIZATION TO ASSIGN BENEFITS

I assign and authorize Medicare/Medicaid/Other insurance payments to this Practice for goods and services provided to me. I understand it is mandatory to notify this practice of any other party who may be responsible for paying for my treatment. I permit a copy of this authorization be used in place of the original. _____ initial

PRIVACY PRACTICES

I acknowledge that the Notice of Privacy Practices has been made available to me. _____ initial

Signature of Patient, Parent, Guardian or Responsible Party

Date

Print Name of Patient, Parent, Guardian or Responsible Party

Relationship to Patient

GENERAL HISTORY

Date of last eye exam _____ Occupation _____
Previous eye doctor _____ Hours spent on computer per day _____
Name of medical doctor _____ Hobbies _____
Date of last medical exam _____ Special visual needs _____

Please turn over and complete side two

Circle any of the following about which you are interested or have questions:

Allergy care Contact lenses Low vision Cataract surgery LASIK Sports vision

YOUR MEDICAL HISTORY

List any medications (Omit this if you brought a list)

Are you pregnant and/or nursing? Yes No

List any medication allergies or contact solution allergies

List all major injuries, surgeries, and/or hospital stays

List any Eye drops or Medications for your eyes

YOUR EYE HISTORY

Circle any of the following that apply to you now or in the past:

- Bleeding in eye* *Eye infection* *Lazy eye* *Cataract* *Eye injury* *Macular degeneration*
- Crossed eyes* *Eye surgery* *Prominent eyes* *Drooping eyelid* *Glaucoma* *Retinal disease*

Others not listed above or details of the above: _____

Do you wear glasses? Yes No

Do you wear contact lenses? Yes No

When did you last get glasses? _____

What type/prescription of contacts? _____

Are they working well? Yes No

Are they comfortable? Yes No

FAMILY EYE HISTORY

Circle any of the following that apply to members of your immediate family and indicate relationship besides the condition (parents, grandparents, siblings, and children):

- Blindness* *Crossed eyes* *Retinal detachment* *Cataract* *Glaucoma* *Color blindness* *Macular degeneration* *Other (specify)*

YOUR SOCIAL HISTORY

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

Do you drive? Yes No What visual difficulties do you have while driving? _____

Do you use tobacco or smoke? Yes No What type/amount/how long? _____

Do you drink alcohol? Yes No What type/amount/how long? _____

Do you use illegal or recreational drugs? Yes No What type/amount/how long? _____

Circle any of the following to which you have been exposed: *Gonorrhea* *HIV/AIDS* *Hepatitis* *Syphilis*

Doctor signature _____

Date _____