PACIFIC EYECARE OF POULSBO
PATIENT REGISTRATION FORM

REFERRED BY:____

PATIENT INFORMATION:

NAME:____DATE:_________________
SSN#:_________________BIRTHDATE:_____________AGE:_____MALE / FEMALE
TELEPHONE (home):_____________(work)_____________(cell)________________
MAILING ADDRESS:____
CITY:_____________________________STATE:_________ZIP:_________________
MARITAL STATUS:________STUDENT STATUS:__________________________
SPOUSES'S NAME:_________________________BIRTHDATE:_______________
SPOUSE'S SSN#:________________________

PERSONAL CONTACT : **(OTHER THAN SPOUSE IF POSSIBLE)**
NAME**:**_____________________________________RELATIONSHIP:______________
PHONE:________________ADDRESS:____
CITY:___________________________STATE:_____ ZIP:__________________________

EMPLOYMENT INFORMATION:
NAME OF EMPLOYER:_________________________OCCUPATION:______________
EMPLOYER'S ADDRESS:____
SPOUSE'S EMPLOYER:_________________________OCCUPATION:______________

RESPONSIBLE PARTY: (IF DIFFERENT FROM PATIENT OR PATIENT IS MINOR)
GUARANTOR:___________________________RELATION TO PATIENT:___________
BIRTHDATE:_____________HOME #:_____________DAYTIME #_________________
MAILING ADDRESS:____
EMPLOYER:__________________________________SSN:__________________________
PERSON WHO BROUGHT IN CHILD______________________**RELATION**_____________

INSURANCE INFORMATION:

	PRIMARY INSURANCE	SECONDARY INS	VISION INSURANCE
NAME:	____________________	____________________	____________________
POLICY #	____________________	____________________	____________________
GROUP #	____________________	____________________	____________________

IF INJURY, DATE____________________**JOB RELATED INJURY? YES or NO**

PLEASE READ & SIGN THE FINANCIAL STATEMENT ON THE BACK OF THIS PAGE:

PACIFIC EYECARE OF POULSBO

INSURANCE AND PAYMENT POLICY

GOOD COMMUNICATION IS ESSENTIAL FOR A HEALTHY DOCTOR-PATIENT RELATIONSHIP, NOT ONLY HEALTH-WISE, BUT ALSO CONCERNING POLICIES TOWARD INSURANCE AND FEES. IF YOU EVER HAVE ANY QUESTIONS REGARDING YOUR ACCOUNT, PLEASE DO NOT HESITATE TO ASK.

WE ARE A PREFERRED PROVIDER FOR MANY INSURANCE COMPANIES, SO PLEASE CHECK WITH OUR OFFICE TO MAKE SURE YOUR PLAN IS ONE OF THESE SO THAT WE CAN BILL CORRECTLY.

WE CAN BILL MOST INSURANCES AS A COURTESY IF WE ARE GIVEN THE PROPER INFORMATION AT THE TIME OF YOUR VISIT. THE PATIENT IS STILL RESPONSIBLE FOR THE BALANCE AT THE TIME OF SERVICE AS MOST INSURANCE COMPANIES WILL SEND PAYMENT TO THE PATIENT DIRECTLY. PLEASE REMEMBER YOUR INSURANCE IS A CONTRACT BETWEEN YOU, YOUR EMPLOYER AND THE INSURANCE COMPANY. WITH MANY OF THE NEW COMPLIANCE REGULATIONS, WE MAY NOT BE ABLE TO OBTAIN INFORMATION FOR YOU AND THIS WILL BE SOMETHING THAT YOU WILL NEED TO CALL AND RECEIVE.

COPAYS ARE ALWAYS DUE AT THE TIME OF SERVICE.

ANY CHARGES NOT COVERED BY YOUR INSURANCE WILL BE DUE AT THE TIME OF YOUR VISIT UNLESS OTHER PAYMENT ARRANGEMENTS HAVE BEEN APPROVED IN ADVANCE.

CONTACT LENS FITTING CHARGES ARE DUE AT THE TIME OF SERVICE UNLESS COVERED BY YOUR INSURANCE WHICH MANY INSURANCES DO NOT COVER.

REGARDING REFERRALS: IF YOUR INSURANCE COMPANY REQUIRES A REFERRAL, THIS WILL BE YOUR OBLIGATION. IF YOU NEED ANY INFORMAION FROM OUR OFFICE WE WILL BE HAPPY TO GIVE THAT TO YOU SO YOU CAN REQUEST YOUR REFERRAL.

PATIENT SIGNATURE ____ DATE ______________

NOTICE OF PRIVACY PRACTICES — ACKNOWLEDGEMENT
PACIFIC EYECARE OF POULSBO

This Notice of Privacy Practices is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act (HIPAA) of 1996

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the office manager.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

PLEASE LIST THE INDIVIDUALS YOU WISH TO PARTICIPATE IN YOUR CARE: This will be someone we can leave messages with regarding appointment times, ask questions regarding insurance and account information, and patient care.

____

CONTACT NAME **RELATIONSHIP/ PHONE#**

____

CONTACT NAME **RELATIONSHIP / PHONE#**

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

____

Patient or legally authorized individual signature DATE

____

Printed name if signed on behalf of the patient

Relationship (parent, legal guardian, personal representative)

This form will be retained in your medical record. Last Update:_____

PACIFIC EYECARE OF POULSBO (PECP)

20669 Bond Rd NE, Ste 100, Poulsbo, WA 98370 PHONE: (360) 779-2020 FAX: (360) 779-3093

AUTHORIZATION TO USE OR DISCLOSE MY HEALTH CARE INFORMATION

Patient Name: ____ Previous Name:________________

DOB: (MM/DD/YYYY)____________________SSN: ________-_____-________

You may use or disclose health care information regarding (check all that apply):

All health care information in my medical record

Health care information in my medical record relating to the following treatment or condition:

____

Health care information in my medical record for the date(s): ____________________________

Other (e.g., x-rays, bills), specific dates: ____

You may use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply):

Psychiatric disorders/Mental Health

HIV (AIDS Virus)

Drug and/or alcohol use

STD's (Sexually transmitted diseases)

Please choose one of the following:

Pacific EyeCare of Poulsbo is obtaining records from another provider as listed below:

Pacific EyeCare of Poulsbo is being asked to provide records to the provider listed below:

Name (or title) and organization: ____

Address: ____

City: ____ State: __________ Zip: __________

Phone Number: __________________________ & Fax Number: ___________________________

Information is to be:

Picked up at PECP office

Mailed to the above address

Faxed to the above (no more than 20 pgs)

Reason(s) for this authorization (check all that apply):

At my request Transferring care Legal Insurance

Other (explain): ____

This authorization ends: *(This document does not permit disclosure of health information created more than 90 days after the date it is signed.)* 90 days from the date signed On (date): _________________

When the following event occurs: ____

(no longer than 90 days from date signed)

My Rights:

I understand I do not have to sign this authorization in order to get health care benefit (treatment, payment, or enrollment). However, I do have to sign an authorization form in order:

- To receive health care when the purpose is to create health care information for a third party or
- To take part in a research study.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Pacific EyeCare based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance.

Two ways to revoke this authorization are:

- Fill out a revocation form. (A form is available at PECP) or
- Write a letter to PECP at 20669 Bond Rd NE, Ste 100, Poulsbo, WA 98370

Once health care information is disclosed, the person or organization that receives it **may** re-disclose it. **Privacy laws no longer protect it.**

____ ______________________

Patient or Legally authorized individual signature Date Time

____ ______________________

Printed name if signed on behalf of the patient Relationship

Pacific EyeCare of Poulsbo

Health History Form

Name: ___________________________________ Today's Date: ___________________

Family Physician: __________________________ Birthdate: _______________________

How were you referred?: ____

CURRENT MEDICAL HISTORY

Do you have any of the following medical illnesses? (circle all that apply): High blood pressure High Cholesterol Diabetes Heart disease Asthma Depression Stroke Clotting disorder AIDS Cancer	List all current eye problems or eye injuries: (**List which eye**)

MEDICATIONS

Use ivory colored form to list medications you are taking:

Drug Allergies:

PAST MEDICAL HISTORY
(when appropriate, list dates and eye involved)

High blood pressure High Cholesterol Diabetes Heart disease Asthma Depression Stroke Clotting disorder AIDS Cancer	List all medical illnesses and surgeries: List previous eye problems or eye injuries:

PERSONAL / SOCIAL / FAMILY HISTORY

Smoking History: Y / N # of packs/ day? ______ # of years? ______

Social History: Marital Status: ___________ Occupation: ___________________________

Family History (please circle all that apply):

Retinal detachment	Loss of vision at a young age	Cataract
Macular degeneration	Congenital defects	Diabetes
Corneal transplant	Blood clotting problems	
Glaucoma	Heart disease	

Please complete other side.

____

Physician signature / Date

Phys Sig/Date____________ Phys Sig/ Date __________ Phys Sig/Date ___________ Phys Sig/Date ___________

Pacific EyeCare of Poulsbo

Health History Form

Please circle what pertains to your health:
(Circle NONE if none applies)

Patient Name: ___________________________________ **Today's Date:** ______________________

- **Constitutional**: **NONE**, headaches, fatigue, fever, insomnia, weight loss, weight gain, or other: __
- **HEENT** (Head, Ears, Nose, Throat)**: NONE**, hearing loss, hoarseness, nasal congestion, pain, sore throat, ringing in ears, dizziness, or other: ____
- **Respiratory**: **NONE**, asthma, shortness of breath, cough, coughing up blood, TB exposure, or other: ____
- **Cardiovascular (Heart)**: **NONE**, palpitations, chest pain, history of heart attack, or other: ____
- **Vascular**: **NONE**, ankle swelling, circulation problems, leg ulcer, or other: __________________ ____
- **Gastrointestinal: NONE**, abdominal pain, constipation, diarrhea, vomiting, nausea, acid reflux, or other: ____
- **Genitourinary: NONE**, incontinence, kidney stones, blood in urine, pain with urination, bladder infections, or other: ____
- **Reproductive:** For Female patients only: Are you pregnant? ______________________________
- **Metabolic/Endocrine: NONE**, weight gain/loss, increased thirst, increased urination, generalized weakness, hair loss, blood sugar abnormalities (explain), or other: ___________________________ ____
- **Neurological/Psychiatric: NONE,** anxiety, dementia, depression, dizziness, headaches, migraines, memory loss, stroke, numbness of extremities, tremors, seizures, dizziness, Alzheimer's, or other: _ ____
- **Dermatological (Skin): NONE**, acne, contact allergy, eczema, hair loss, pigment changes, rashes, skin lesions, or other: ____
- **Musculoskeletal: NONE**, back pain, bone/joint symptoms, muscle pain, rheumatism, or other: __ ____
- **Hematological (Blood): NONE**, bruises easily, HIV virus, prior transfusion, or other: _________ ____
- **Immunological: NONE**, asthma, bee sting allergies, environmental allergies, food allergies, hay fever, or other:____
- Have you ever taken steroid medication of any kind? **Y / N** If so, why? ____
- Are you taking aspirin, aspirin related products or blood thinners? ___________________________
- Any other conditions we should be aware of? ____ ____ ____

____

Patient signature/Date Physician signature / Date

Patient Name: **DOB:** **Date:**

Date Started	NAME OF MEDICATION / DOSAGE / STRENGTH	Date Stopped	Office Use Only

E-EPRESCRIBE F-FAX HW-HANDWRITTEN P-PRINT

PACIFIC EYECARE OF POULSBO