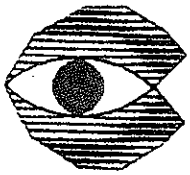

PASCO EYE INSTITUTE
Patient Information Form

PATIENT REGISTRATION

First Name _____ Initial _____ Last Name _____

Home Address _____ City, State, Zip _____

Home Phone (_____) _____ Work Phone (_____) _____

Cell (_____) _____ Email _____

Sex: Male Female Date of Birth _____ Soc Sec #: _____

Race: White Black/African American Asian Other _____ Prefer Not to Answer: _____

Ethnicity: Hispanic/Latino Not Hispanic/Latino _____ Prefer Not to Answer: _____

Referring Doctor: _____ Ph# _____

Primary Care Physician: _____ Ph# _____

Employer _____

Emergency Contact _____ Relationship _____ Phone _____

INSURANCE INFORMATION

Primary Insurance _____

Policy Holder Name _____ DOB _____ SS# _____

Policy I.D. _____ Group # _____

Patient Relation to Policy Holder: Self Spouse Child Other _____

Secondary Insurance _____

Policy Holder Name _____ DOB _____ SS# _____

Policy I.D. _____ Group _____

BILLING INFORMATION

All professional services rendered are the responsibility of the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. Authorization to pay benefits to Provider: I hereby authorize payment directly to the undersigned Provider for my charges. Authorization to Release Information: I hereby authorize the undersigned Provider to release any information acquired in the course of my examination or treatment to my insurance company in writing or by fax.

Signature (Patient,Guardian,Parent of Minor) _____ Date _____

MEDICAL HISTORY QUESTIONNAIRE

Name:_____ Date:_____

Date of Last Eye Exam:_____ Where_____

List any medications you currently take (prescription and over-the-counter):_____

_____

_____

Do you have allergies to any medications? ☐ YES ☐ NO

If **YES**, list the medications:_____

_____

Do you have seasonal allergies?_____

List all major illnesses (glaucoma, diabetes, high blood pressure, heart attack,etc.) or injuries (concussion, etc.):_____

_____

List any surgeries you have had (cataract, tonsillectomy, appendectomy): _____

_____

_____

_____

Do you currently have any problems in the following areas? If "**YES**," please provide information.

	YES	NO	Explanation of Problem
EYES (Glaucoma, cataract, retinal disease, etc.)			
Blurred vision			
Fluctuating vision			
Distorted vision (halos)			
Loss of side vision			
Double vision			
Dryness			
Redness			
Sandy, gritty feeling, discharge			
Itching, burning			
Foreign body sensation			
Excess tearing/watering			
Glare/light sensitivity			
Eye pain or soreness			
Infection of eye or lid (Blepharitis, stye)			
Tired eyes			
Crossed eyes, lazy eye			
Drooping eyelid			
GENERAL/CONSTITUTIONAL			
Fever			
Weight Loss			
EARS, NOSE, THROAT			
(Sinus, ear infection, chronic cough, dry mouth, etc.)			

	YES	NO	Explanation of Problem
CARDIOVASCULAR (Heart, vessels, etc.)			
RESPIRATORY (asthma, emphysema, etc.)			
GASTROINTESTINAL (Stomach ulcers, intestinal disease, etc.)			
GENITAL, KIDNEY, BLADDER			
MUSCLES, BONES, JOINTS (Arthritis, etc.)			
SKIN (Acne, warts, skin cancer, etc.)			
NEUROLOGICAL (Multiple sclerosis, etc.)			
PSYCHIATRIC (Anxiety, depression, insomnia)			
ENDOCRINE (Diabetes, hypothyroid, etc.)			
BLOOD/LYMPH (Anemia, etc.)			
ALLERGIC/IMMUNOLOGIC (Hay fever, lupus, Sjogrens, etc.)			

FAMILY HISTORY M=Mother F=Father S=Sibling GP=Grandparent

Does or did a family member ever have:

DISEASE	YES	NO	RELATIONSHIP TO PATIENT
Blindness			
Glaucoma			
Arthritis			
Cancer			
Diabetes			
Heart disease or high blood pressure			
Kidney disease			
Lupus			
Stroke			
Thyroid disease			
Other			

SOCIAL HISTORY

Current occupation (if retired-previous occupation):_____
Marital status (married, divorced, singe, widowed):_____

Do you drive? ☐ Yes ☐ No
Do you have visual difficulty when driving? ☐ Yes ☐ No
Do you have problems with night vision? ☐ Yes ☐ No
Have you ever worn contact lenses? ☐ Yes ☐ No
If yes, how long have you worn them?_____
Do you currently wear glasses? ☐ Yes ☐ No
If **YES**, when were they last changed?_____
Do you drink alcohol? ☐ Yes ☐ No If **YES**: occasional 1 per day 2-3 per day 4+ per day
Do you smoke? ☐ Yes ☐ No If **YES**: occasional ½ pack/day 1 pack/day 1 + pack
Have you ever had a blood transfusion? ☐ Yes ☐ No
History reviewed. ☐ No Changes ☐ Additions as noted above. _____Initials

PASCO EYE INSTITUTE

PATIENT ACKNOWLEDGEMENT OF HAVING READ OR BEEN READ THE NOTICE OF HEALTH INFORMATION PRACTICES

I have been provided the opportunity to read, or it has been read to me, the Notice of Health Information Practices at **F. A. Hauber, M.D., P.A., dba/Pasco Eye Institute.**

I understand that **Pasco Eye Institute** is committed to treating and using protected health information about me responsibly.

I understand my rights as it relates to my records at **Pasco Eye Institute** and understand how information about me may be used and disclosed.

I understand that my health record is the physical and legal property of **Pasco Eye Institute**, but the information belongs to me. I may have access to inspect, amend or obtain a copy of my health information.

I understand that **Pasco Eye Institute** is required to maintain the privacy of my health information. **Pasco Eye Institute** will require my authorization to release my health information to outside sources with the exception of disclosures for purposes of Treatment, Payment and Healthcare Operations. These may include: access to my health information by **Pasco Eye Institute's** staff and physicians; billing to myself or a third-party payer; in addition, business associates of **Pasco Eye Institute**, may from time to time, have access to my health information, but, I am assured that proper Business Associates Agreements are in place, insuring the protection of my health information; upon the physicians best judgment, he/she may disclose to a family member, relative or close personal friend or any other persons you identify, health information relevant to that person's involvement in my care; may be used for research data; funeral directors; organ procurement; marketing; FDA; public health or legal authorities; and/or law enforcement purposes.

Pasco Eye Institute may call me with appointment reminders, cancellations and may leave voice mail messages at my home or place of employment.

I have read and understand the Health Information Practices of **Pasco Eye Institute**.

_____ _____

Patient's Signature Date