Please, DO NOT wear PERFUME, COLOGNE or SCENTED LOTIONS to your appointment. Please make sure the person(s) accompanying you to your appointment adhere to this rule as well. Our staff members experience a severe allergic reaction to these products, and if you, or the person accompanying you chooses to wear PERFUME, COLOGNE or SCENTED LOTIONS we will have to reschedule your appointment. There are NO exceptions to this rule!

TRI-STATE EYE
Physician and Surgeon

Patient Information

You may visit our website at www.tristateeye.com

Welcome to our office. Please complete **all four pages** of this form and return it to the receptionist, who will use the information to prepare your chart.

If a REFERRAL is required, please give it to the receptionist upon arrival.

CO-PAYMENTS ARE DUE AT TIME OF VISIT!

PLEASE PRINT:

1. Name _____ Date _____

2. **Mailing Address**_____
   Street City State Zip

3. Date of Birth _____ Age _____ Sex M/F _____

   Social Security # _____

4. Telephone (Daytime) _____ Telephone (Evening) _____

5. Occupation _____ Employer _____

6. Name of Spouse _____ Employer _____
   Please Check Single Married Widowed Divorced

Name of Person(s) you will allow office to discuss medical status with:_____

7. **Complete if under 18 years or a student**
   Name of Father_____ Employer _____
   Name of Mother_____ Employer_____

8. How did you hear about our practice?_____

9. Are you personally responsible for the payment of your fees? Yes No
   If no, who is?
   Name_____ Relationship_____
   Address_____
   Social Security #_____

10. Is any part of your eye examination covered by insurance? Yes No
    (If no, skip to question 14)

11. Primary Insurance Company_____
    Subscriber_____ Social Security#_____

12. Secondary Insurance Company_____
Subscriber _____Social Security#_____

13. Person to contact in case of Emergency: Name_____
Relationship_____
Address_____
Phone_____

14. Briefly explain any current eye problems.

_____
_____

Medical History

PLEASE CK YES/NO IN FOLLOWING SIX AREAS!

Family History

Yes No

- ☐ ☐ Glaucoma_____
- ☐ ☐ Strabismus (Cross Eyes)_____
- ☐ ☐ Cataracts_____
- ☐ ☐ Blindness_____
- ☐ ☐ Diabetes_____
- ☐ ☐ Other_____

Eye History (check and explain):

Yes No

- ☐ ☐ Glaucoma_____
- ☐ ☐ Muscle Imbalance_____
- ☐ ☐ Retinal Problems_____
- ☐ ☐ Eye Injuries_____
- ☐ ☐ Cataracts_____
- ☐ ☐ Infections_____
- ☐ ☐ Double Vision_____
- ☐ ☐ Blurred or fuzzy vision_____
- ☐ ☐ Eye Surgery_____
- ☐ ☐ Eye Laser_____

Social History

Yes No

- ☐ ☐ Smoking_____
- ☐ ☐ Alcohol Use_____
- ☐ ☐ Surgery_____
- ☐ ☐ Bleeding Tendency_____
- ☐ ☐ AIDS_____
- ☐ ☐ On Oral Contraceptives_____

Yes No: Cont.

- ☐ ☐ Now Pregnant_____
- ☐ ☐ Other_____

Review of Systems

Yes No

General Health_____

- ☐ ☐ Cardiac/High Blood Pressure
- ☐ ☐ Lung/Asthma_____
- ☐ ☐ Endocrinology/Diabetes_____
- ☐ ☐ Neurologic_____
- ☐ ☐ Ear/Nose/Throat_____
- ☐ ☐ Musculoskeletal/Arthritis_____
- ☐ ☐ Skin_____
- ☐ ☐ Gastro/Intestinal_____
- ☐ ☐ Cancer_____
- ☐ ☐ Psych_____
- ☐ ☐ Allergies_____

Current Eye Problems (check and explain):

Yes No

- ☐ ☐ Pain, itching, burning, or Scratching sensation_____
- ☐ ☐ Redness_____
- ☐ ☐ Tearing or discharge_____
- ☐ ☐ Blurred or fuzzy vision_____
- ☐ ☐ Flashing lights_____
- ☐ ☐ Problems with glasses_____
- Cobwebs, dark spots, or Veils_____
- ☐ ☐ Other _____

15. Please list any medications you are currently taking and the dosage.
_____
_____

Are you allergic to any medications? Please specify.
_____
_____

Date of last eye exam_____ Doctor_____
Address_____
May we send for your old records? _____ Signature_____

Do you now wear glasses?____ Have you worn glasses in the past?____
How old are your reading glasses?_____ Distance?_____
Do you wish to have your glasses changed?_____
Do you now wear contact lenses?___ If so, for how long?_____
Hard Soft Type, if known_____
How many hours per day?_____
If no, have you ever worn contact lenses?_____

Are you interested in Laser/Vision Corrective/Refractive Surgery?_____

THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE.

I request that direct payment of authorized benefits from my Medicare and/or commercial insurance carrier be made to Tri-State Eye, Inc. for services rendered on my behalf. I authorize any holder of medical information about me to release to the Centers for Medicare, Medicaid services, and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorized release of medical information necessary to pay the claim. Signature below also allows Tri-State Eye to file Medicare claims electronically. Tri-State Eye accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier. ***Co-Payments are due at the time of visit!***

PLEASE SIGN BELOW!

Beneficiary Signature or Authorized Party_____

Date_____

PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent.

This Consent was signed by: _____

Sign & Print Name– Patient or Representative

Relationship to Patient (if other than patient):_____

Date:_____ / /

In front of _____

Printed name – Practice representative