MCPHERSON FAMILY EYE CARE. OD. PA

3150 ROGERS ROAD SUITE # 110 | WAKE FOREST, NC 27587
WWW.MCPHERSONFAMILYEYECARE.COM
919-263-9163

PATIENT REGISTRATION

PATIENT INFORMATION

Patient Name _____ Date of Birth _____

Address _____

Home Phone _____ Cell Phone _____ Work Phone_____

Email _____

Race _____ Ethnicity _____

Marital Status [Single / Married / Divorced / Separated / Widowed] SSN _____

Occupation _____ Employer _____

How did you hear about us? [Internet search / Mailer / Wake Weekly / Patient / Drive by / Reminder / Other _____]

ACCOUNT RESPONSIBLE

Name _____ Date of Birth _____

Relationship _____ SSN _____

Address _____

Home Phone _____ Cell Phone _____ Work Phone _____

PRIMARY INSURANCE

Name _____ Group Name _____

ID # _____ Group # _____

Policy Holder _____ Date of Birth _____

SECONDARY INSURANCE

Name _____ Group Name _____

ID # _____ Group # _____

Policy Holder _____ Date of Birth _____

EMERGENCY CONTACT

Name _____ Phone _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I understand the privacy of my health information is protected under "HIPAA" and that I have certain rights regarding that information. I acknowledge that I have been offered or received a copy of this practice's **Notice of Privacy Practice**.

Patient Signature _____ Date _____

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PATIENT MEDICAL HISTORY FORM

YOUR MEDICAL HISTORY

List any medications you are currently taking, including over the counter medications and herbal supplements:

_____

List any allergies & your reaction: _____

Name of Family Doctor: _____ Date of last medical exam: _____

Previous Eye Doctor: _____ Date of last eye exam: _____

Have you had any surgeries, including eye surgery? If yes, please list type and approximate date: Y / N

_____

Have you had any major injuries, or hospitalizations? Y / N

_____

Are you currently pregnant or nursing? Y / N

Do you smoke? Y / N If yes, when did you start? _____ How many packs per day? _____

If no, are you a former smoker? Y / N

Do you consume alcohol? Y / N If yes, how much? _____

Preferred Pharmacy (name and location): _____

YOUR FAMILY HISTORY

Has anyone in your family been diagnosed with any of the following (check all that apply & list family member):

☐ Diabetes _____ ☐ High blood pressure _____
☐ Heart Disease _____ ☐ Cancer--type: _____

Has anyone in your family been diagnosed with any of the following eye problems (check all that apply & list):

☐ Strabismus _____ ☐ Amblyopia (lazy eye) _____
☐ Retinal Detachment _____ ☐ Glaucoma _____
☐ Macular Degeneration _____

Do you wear glasses? Y / N Do you wear contact lenses? Y / N Would you like to try contact lenses? Y / N

REVIEW OF SYMPTOMS

Do you currently, or have you ever had any problems in the following areas?
Please circle the condition(s) that you have. To indicate a past problem, write a "P" next to the condition. All of these may affect the health of your eyes.

Ocular/Eye Problems Glaucoma Amblyopia (Lazy Eye) Cataract Inflammatory Disease Dry Eye Retinal problems Macular Degeneration Strabismus (Eye Turn)	**Constitutional Problems** Fever Weight Loss/Gain Cancer Fatigue Developmental Disability	**Ear/Nose/Mouth/Throat Problems** Allergies/Hay Fever Sinus Congestion Laryngitis Dry Mouth Hearing Loss Sinusitis
Neurological Problems Headaches Cerebral Palsy Multiple Sclerosis Tumor Epilepsy	**Psychiatric Problems** Depression Anxiety	**Cardiovascular Problems** Vascular Disease Stroke Congestive Heart Failure Heart Disease High Blood Pressure High Cholesterol
Respiratory Problems Emphysema Bronchitis COPD Asthma	**Gastrointestinal Problems** Colitis Crohn's disease Ulcer Irritable Bowel Syndrome	**Genitourinary Problems** Prostate Disease/Cancer STD Kidney Disease
Musculoskeletal Problems Ankylosing Spondylitis Fibromyalgia Muscular Dystrophy Osteoarthritis	**Skin Problems** Rosacea Psoriasis Eczema	**Endocrine Problems** Insulin Dependent Diabetes (Type I) Non-Insulin Diabetes (Type II) Hormonal Dysfunction Thyroid Dysfunction (Hypo/Hyper)
Blood/Lymph Problems Anemia Large volume blood loss	**Allergy/Immunologic Problems** Rheumatoid Arthritis Lupus Allergies: Drug/ Environmental	**Other: Please list**

CONSENT FOR TREATMENT: I HEREBY AUTHORIZE MCPHERSON FAMILY EYE CARE TO ADMINISTER DIAGNOSTIC AND MEDICAL PROCEDURES AS MAY BE NECESSARY FOR PROPER HEALTH CARE.
CONSENT FOR E-PRESCRIBING: I HEREBY AUTHORIZE MCPHERSON FAMILY EYE CARE TO SEND ANY PRESCRIPTIONS FOR MEDICATIONS TO MY PHARMACY BY WAY OF E-PRESCRIBING.

_____ _____

Printed Name of Patient Date

_____

Signature

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AUTHORIZATION FOR RELEASE OF INFORMATION

I, (patient name)_____, authorize McPherson Family Eye Care to release my protected health information to the identified person(s) listed here:

_____

_____

SELECT THE APPROVED METHOD OF COMMUNICATION TO THE PERSON(S) LISTED ABOVE.

- ☐ Phone/Voice Mail
- ☐ Email communication – Provide email address*

_____

- ☐ Text communication – Provide phone number *

_____

- ☐ Check here if you do not wish for any person(s) to have access to your protected health information.

INFORMATION APPROVED TO BE RELEASED. CHECK EACH THAT CAN BE GIVEN TO THE AFOREMENTIONED PERSON/ENTITY.

- ☐ Continuing Medical Care / Referral Appointments
- ☐ Scheduling Appointments / Appointment Reminders
- ☐ Results of Testing / Photos / Finalized Prescriptions
- ☐ Financial/Insurance
- ☐ Dispensing Glasses or Contact Lenses
- ☐ Other:

_____

***DISCLOSURE: FOR EMAIL AND/OR TEXT COMMUNICATION I UNDERSTAND THAT IF INFORMATION IS NOT SENT IN AN ENCRYPTED MANNER THERE IS A RISK IT COULD BE ACCESSED INAPPROPRIATELY. I STILL ELECT TO RECEIVE EMAIL AND/OR TEXT COMMUNICATION AS SELECTED.**

PATIENT RIGHTS:

- ✓ I have the right to revoke this authorization at any time.
- ✓ I may inspect or copy the protected health information to be disclosed as described in this document.
- ✓ Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- ✓ Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- ✓ I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL REVOKED BY THE PATIENT.

_____ _____

Signature of Patient or Personal Representative Date

**Description of Personal Representative's Authority (attach necessary documentation)*

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REQUEST FOR RELEASE OF VISION RECORDS

_____
Patient Name

_____ _____
Date of Birth Last 4 digits of SSN

I THE UNDERSIGNED, HEREBY AUTHORIZE:

MCPHERSON FAMILY EYE CARE
3150 ROGERS ROAD SUITE 110
WAKE FOREST, NC 27587
PHONE: 919-263-9163 FAX: 919-263-9408

TO DISCLOSE ALL INFORMATION RELATING TO MY MEDICAL AND VISION STATUS TO:

_____
Doctor or Facility

_____
Address

_____ _____
Phone Fax

- ✓ By signing below, I hereby consent and authorize the release of my medical records, including current and past records.
- ✓ I understand that there is the potential for re-disclosure of my medical records.
- ✓ I understand that I may revoke this consent at any time except to the extent that action has already been taken on it.
- ✓ This request will automatically expire 1 year from the date indicated below.

_____ _____
Signature of Patient or Personal Representative Date

**Description of Personal Representative's Authority (attach necessary documentation)*

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

_____
Patient Name

_____
Address

_____
City, State, ZIP

I HAVE BEEN PROVIDED AN OPPORTUNITY TO VIEW A COPY OF THE NOTICE OF PRIVACY PRACTICES FOR THE ABOVE-NAMED PRACTICE.

_____ _____
Patient Signature Date

FOR OFFICE USE ONLY

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ☐ An emergency existed & a signature was not possible at the time.
- ☐ The individual refused to sign.
- ☐ A copy was mailed with a request for a signature by return mail.
- ☐ Unable to communicate with the patient for the following reason: _____
- ☐ Other: _____

Prepared By: _____

Signature: _____ Date: _____